

Dispensing Medication to Dependent Adults and Minors Guidelines – SECC

For safety reasons, dependent adult and minor participants (“Participants”) may not hold, transport, carry, or otherwise be in possession of any prescriptions or non-prescription medications while on a church-sponsored trip, except as required by law or governmental regulation.

I. Parental Responsibilities

If a Participant needs to take prescription or non-prescription medicines, the parent/ guardian must complete the *Medication Information and Permission to Dispense Medication* Form.

1. Deliver this completed form AND the prescription and non-prescription medication in its original bottle or in a clearly marked container that includes the Participant’s name, medication, dosage, and time of day medication is to be given.
2. Verbally communicate with SECC staff or medical professionals and Lay Leaders regarding specific instructions for medication.

II. Required Medication Dispensing Procedures

1. Ensure the form is fully completed and signed by the parent/guardian prior to the dispensing of any medication.
2. Ensure only authorized SECC staff or medical professionals and Lay Leaders accept medication.
3. Verbally communicate with the parent or guardian regarding any specific instructions regarding the dispensing/storage of the medication. It is also the responsibility of those receiving medication to properly store medication in a secured room or in a refrigerator if needed. It is extremely important that stored medication is out of the reach of other Participants and particularly minors.
4. Obtain copies of releases, internal procedures, medical information forms, and medication logs when receiving the medication to be transported to the location of the event. All medication stored at a program site must be secured and only available to authorized SECC representatives and Lay Leaders.
5. SECC program leaders responsible for dispensing medications must strictly follow all written instructions on the medical information form, individual dose envelopes, and any information contained on the original container label. If conflicting dispensing information exists, do not administer the medication until the parent, guardian or physician is reached by phone to clarify instructions.
6. Unless otherwise arranged, only SECC staff or medical professionals and Lay Leaders will be allowed to dispense medication.
7. Participants who use asthma inhalers or epinephrine auto injector (Epi-pens) may be allowed to carry these medications with them at all times. However, these medications must be listed on the Participant’s list of medications and program leaders must consult with the parent/guardian.
8. Persons responsible for dispensing medication must complete the information on the medication log form.
9. Return Medication Information, Permission to Dispense Medication Forms, and Medication Logs to Legal Department after event.

OTHER INFORMATION:

PERMISSION TO DISPENSE MEDICATION AND LEGAL RELEASE:

On behalf of myself and my dependent adult or child (referred to above as the Participant, and hereafter as "my dependent"), I hereby fully and forever release and waive and agree not to bring or cause to be brought any and all claims, demands, actions or causes of action of every possible kind and nature whatsoever (including without limitation, any claim of negligence) I might assert, whether or not absolute, known or unknown, or otherwise against Southeast Christian Church of Jefferson County, Kentucky, Inc. or any of its elders, officers, employees, agents, lay leaders or volunteers (all being hereafter collectively referred to herein as the "Releasees") by reason of, arising out of or relating to the administration of medication to my dependent in accordance with instructions that I set out above. I also give permission to the Releasees to contact and discuss my dependent's medical condition with the medical professionals I listed above or such other professionals as may be necessary. I attest that I am either (1) the parent and custodian of my dependent named herein, or (2) the duly appointed legal guardian of my dependent named herein.

Signature of Parent/Guardian: _____ Date: _____, 20 __

Printed name of Parent/Guardian _____ Date: _____, 20 __

Medication Information and Permission to Dispense Medication Form

Complete for each program/event.

PARTICIPANT INFORMATION (Please PRINT)

Participant's Name: _____ Date of Birth: _____

Address: _____

Parent's/Guardian's Name(s): _____

Daytime Phone: _____ Emergency Phone: _____

Event: _____ Date(s) of Event: _____

MEDICATION(S) INFORMATION TO BE ADMINISTERED:

***Prescription label must match list and medication log* (Please PRINT)**

MORNING:

Name of Medicine: _____

Name of Medicine: _____

Name of Medicine: _____

AFTERNOON:

Name of Medicine: _____

Name of Medicine: _____

Name of Medicine: _____

EVENING/NIGHT:

Name of Medicine: _____

Name of Medicine: _____

Name of Medicine: _____

AS NEEDED (PRN):

Name of Medicine: _____

Name of Medicine: _____

Received at
Check In

MEDICATION ADMINISTRATION FORM

NOTE: All medications MUST be in their original containers

Participants Name _____

Event: _____ Date _____

This section to be filled out by Parent's/Guardian's of student (Please PRINT)

Name of Medication #1:
 Amount to Be Given:
 Times to be given:

Time of Day	S	M	T	W	TH	F	S
Breakfast							
Lunch							
Dinner							
Bedtime							
Other							

Name of Medication #2:
 Amount to Be Given:
 Times to be given:

Time of Day	S	M	T	W	TH	F	S
Breakfast							
Lunch							
Dinner							
Bedtime							
Other							

Name of Medication #3:
 Amount to Be Given:
 Times to be given:

Time of Day	S	M	T	W	TH	F	S
Breakfast							
Lunch							
Dinner							
Bedtime							
Other							

Name of Medication #4:
 Amount to Be Given:
 Times to be given:

Time of Day	S	M	T	W	TH	F	S
Breakfast							
Lunch							
Dinner							
Bedtime							
Other							

Comments:

Initials: _____ Name: _____ Signature: _____
 Initials: _____ Name: _____ Signature: _____
 Initials: _____ Name: _____ Signature: _____

MEDICATION ADMINISTRATION FORM

NOTE: All medications MUST be in their original containers

Participants Name _____

Event: _____ Date _____

This section to be filled out by Parent's/Guardian's of student (Please PRINT)

Name of Medication #1:
 Amount to Be Given:
 Times to be given:

Time of Day	S	M	T	W	TH	F	S
Breakfast							
Lunch							
Dinner							
Bedtime							
Other							

Name of Medication #2:
 Amount to Be Given:
 Times to be given:

Time of Day	S	M	T	W	TH	F	S
Breakfast							
Lunch							
Dinner							
Bedtime							
Other							

Name of Medication #3:
 Amount to Be Given:
 Times to be given:

Time of Day	S	M	T	W	TH	F	S
Breakfast							
Lunch							
Dinner							
Bedtime							
Other							

Name of Medication #4:
 Amount to Be Given:
 Times to be given:

Time of Day	S	M	T	W	TH	F	S
Breakfast							
Lunch							
Dinner							
Bedtime							
Other							

Comments:

Initials: _____ Name: _____ Signature: _____
 Initials: _____ Name: _____ Signature: _____
 Initials: _____ Name: _____ Signature: _____