

CHAPEL HILL PARKS AND RECREATION DEPARTMENT

MEDICINE PERMISSION FORM

I _____ (parent/guardian name – please print), having read the GIVING MEDICATIONS TO PARTICIPANTS POLICY AND PROCEDURES, and, understanding the contents, give my approval for Chapel Hill Parks and Recreation staff or volunteers to give the prescribed medications listed on this MEDICINE PERMISSION FORM, to my child/guardian _____, according to the directions listed on the medication label and/or written by my child's doctor.

I understand that if my child has a serious illness or injury while in our program, 911 Emergency Services will be called and proper medical care given until you, the parent(s) or guardian(s) is contacted. By law, a child under 18 years of age, who needs medical attention beyond what Emergency Services can provide, and whose parents cannot be reached for direction about their care, will be immediately brought by Emergency Services to the nearest emergency facility. All financial costs for transportation and emergency care is the parent/guardian's responsibility.

I understand the above conditions, and understand that the only responsibility or liability assumed by Chapel Hill Parks and Recreation is to follow the instructions given by my child's doctor. I hereby assume all risk and hazards that may happen while my child is participating in this program, including transportation to and from all activities, and do so hereby waive, release, absolve, indemnify and agree to hold harmless the Town of Chapel Hill, its officers, agents and employees, the Parks, Recreation and Greenways Commission, the counselors and directors, from any claims arising out of injury to the child named above. I give permission to UNC Hospitals and/or other licensed medical facilities to provide treatment as deemed necessary by them.

Parent/guardian Signature

Date

NOTE: Complete pages 2 and 3, including your child's name, and sign and date page 3.



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MEDICINE PERMISSION FORM *continued*

PLEASE PRINT ALL INFORMATION IN INK:

Child's Name: _____ Current age: _____

Home Address: _____
street apartment town

Parent or Guardian's Name: _____

Phone 1: _____ Phone 2: _____ Phone 3: _____

Parent or Guardian's Name: _____

Phone 1: _____ Phone 2: _____ Phone 3: _____

Doctor's Name: _____ Office Phone #: _____

PRESCRIPTION MEDICATION LIST

Medication Name #1: _____

Why does your child take this medicine? _____

Dosage and schedule during program hours: _____

Special instructions: _____

Side effects: _____

Medication Name #2: _____

Why does your child take this medicine? _____

Dosage and schedule during program hours: _____

Special instructions: _____

Side effects: _____

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MEDICINE PERMISSION FORM continued Child's Name: _____

Medication Name #3: _____

Why does your child take this medicine? _____

Dosage and schedule during program hours: _____

Special instructions: _____

Side effects: _____

◆ Epinephrine Injection

Give the injection indicated below immediately after report of exposure to: _____

_____ EpiPen Given in pre-measured dose of 0.3 mg epinephrine 1:1000 aqueous solution or 0.3 cc.)

_____ EpiPen Given in pre-measured dose of 0.15 mg epinephrine 1:2000 aqueous solution or 0.3 cc.)

_____ Repeat dose of epinephrine in 15 minutes if Emergency Services has not arrived.

◆ Self-medicate with an Asthma Inhaler

Name of asthma inhaler medication #1: _____

Instructions: _____

Name of asthma inhaler medication #2: _____

Instructions: _____

◆ Authorization for the Child or Teen to Carry and Self-Administer Medication

_____ The child named above, who is under 18 years of age, may self-medicate in the presence of a staff member or volunteer. The prescribed medication will be kept in a locked area away from other children. Each instance of self-medication will be recorded with the date and time taken

Parent/guardian Signature

Date

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