Document 11

Medication and EpiPen® Authorization & Waiver of Liability

Name of Child: Last _____ M.I._____ First: _____
Address: _____
Home Phone: _____ Alternate Phone Number: _____

Contact Information:	**Parent/Guardian #1**	**Parent/Guardian #2**
Name:	_____	_____
Home Phone:	_____	_____
Work Phone:	_____	_____
Cell Phone:	_____	_____
Email:	_____	_____

Emergency Contact: (Person to notify if parents cannot be reached)
Name: _____
Relationship to Camper: _____
Home Phone: _____ Work: _____ Cell: _____

ALLERGIES

Please include the severity of reaction, degree of exposure, frequency of reaction and management/treatment of the reaction.

- ❑ Drug _____
- ❑ Food _____
- ❑ Insect Stings/Bites _____
- ❑ Seasonal Allergies _____
- ❑ Other _____

ALLERGY MANAGEMENT/EPIPEN®S

- ❑ Does your child need an EpiPen®? **Yes ____ No ____**
  If no proceed to the back side of the form. If yes answer the following questions.
- ❑ Does your child understand his/her allergies and take reasonable precautions to avoid the allergens? **Yes ____ No ____**
- ❑ Does your child carry an EpiPen®? **Yes ____ No ____**
- ❑ Does your child know how to administer his/her EpiPen®? **Yes ____ No ____**
- ❑ Do you recommend this EpiPen® be kept on person by the child? **Yes ____ No ____**
- ❑ Is self-medication permitted and recommended for this child? **Yes ____ No ____**
- ❑ Is there any specific storage requirements for this medication? _____
  _____

Over

MEDICATION AUTHORIZATION

Name of Medication_____
Reason for Taking(optional)_____
Dosage:_____
Time to be Given:_____
Method:_____
Dates to be Given:_____
Potential Side Effects/Contradictions/Adverse Reactions:
_____
_____
Does medication require refrigeration? **Yes**____ **No**____
Is self-medication permitted and recommended for this child? **Yes**____ **No**____
If asthma inhaler or emergency medication, do you recommend this
medication be kept "on person" by the child? **Yes**_____ **No**_____

PLEASE READ CAREFULLY

Medication must be left with the Program Supervisor or his/her designee. It must be in the original container, and be clearly labeled with your child's full name, prescriber's name, directions for administration and expiration date.

I hereby authorize Bellevue Parks Department employees and agents, on my behalf, to administer or attempt to administer to my child, or to allow my child to self-administer, the lawfully prescribed medication described above, including a prescribed EpiPen®.
I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE MEDICATION TO BE ADMINISTERED TO MY CHILD BY AN INDIVIDUAL WHO IS NOT A NURSE OR MEDICAL PROFESSIONAL, AND I SPECIFICALLY CONSENT TO SUCH PRACTICE. I hereby waive any claim for myself, my heirs, executors, assigns, or personal representative that I might have against the City of Bellevue, its employees, officials, or agents from and against any and all claims, damages or causes of action arising out of or in any way connected to the self-administration, administration, failure to administer, or attempt to administer medication to my child. I further agree to protect, indemnify, defend, and hold harmless the City of Bellevue, its employees, officials, or agents, arising out of or in any way connected to the self-administration, administration, failure to administer, or attempt to administer medication to my child.

Parent/Guardian Signature _____
Date_____
Printed Name_____

I authorize and recommend self-medication by my child for the above medications(s).

Parent/Guardian Signature _____
Date_____
Printed Name_____