



Medication and Epinephrine Auto - Injector 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/Epinephrine Auto-Injectors

- Does your child need an Epinephrine Auto-Injector? 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 Epinephrine Auto-Injector? Yes ____ No ____
- Does your child know how to administer his/her Epinephrine Auto-Injector? Yes ____ No ____
- Do you recommend this Epinephrine Auto-Injector 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 Epinephrine Auto-Injector.

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 _____