Participant Allergy and Medication Form

PROGRAM

Program Name: _____

PARTICIPANT INFORMATION

Name: | Parent/Guardian Name(s):

Emergency Contact Name: | Phone #:

ALLERGY INFORMATION

Does your child have any life-threatening allergies or medical conditions? If yes, please list the allergy, triggers and symptoms/warning signs below.

1. Allergen (substance or condition that causes an allergic reaction): _____

   Is this an anaphylactic allergy? ◯ Yes ◯ No
   Is an EPI Pen provided for this allergy? ◯ Yes ◯ No

   Symptoms and Warning Signs: _____

   _____

   The onset of the allergic reaction is brought on by: (check all that apply)

   ☐ Ingestion ☐ Touching it ☐ Smelling it ☐ Other _____

2. Allergen (substance or condition that causes an allergic reaction): _____

   Is this an anaphylactic allergy? ◯ Yes ◯ No
   Is an EPI Pen provided for this allergy? ◯ Yes ◯ No

   Symptoms and Warning Signs: _____

   _____

   The onset of the allergic reaction is brought on by: (check all that apply)

   ☐ Ingestion ☐ Touching it ☐ Smelling it ☐ Other _____

MEDICAL INFORMATION

The Town of Richmond Hill Community Services Department will provide a medication supervision service; however, the program participants are encouraged to accept the maximum responsibility for self-administering their medication. Richmond Hill staff will dispense medication for self-administration by a program participant and, if necessary, will provide a hand-over-hand technique dependent upon the situation and abilities of the participant involved. Any changes to dosage and/or medication administration needs must be documented on a new Participant Registration Form.

I understand that any medication that needs to be dispensed to my child will be kept in a locked box and will be dispensed at the agreed upon time as stated below. I agree to provide to staff, on a daily basis, the daily prescribed dosage of medication in the container the medication was in when purchased with the following information clearly identified on it:

Child's Name
Pharmacy Name and Phone Number
Doctor's Name and Phone Number
Name of Medication
Dosage and Time to Administer Medication

I release the Town of Richmond Hill and its staff from any liability or loss, damage or injury, however caused, to my child's person or property arising out of dispensing or failure to dispense the medication as provided herein.

Name on Medication: _____ **Dosage:** _____

Time to Dispense Medication: _____ **Does Medication Require Refrigeration?:** ◯ Yes ◯ No

Instructions for dispensing medication and potential side effects: _____

_____ _____ _____

Parent/Guardian Name (please print) **Parent/Guardian Signature** **Date**