AUTHORIZATION FOR EMERGENCY OR MEDICAL CARE FOR PARTICIPANTS WITH MEDICAL NEEDS OR SEVERE ALLERGIES

Physician: _____ Date: _____

Your patient, _____ will be participating in certain events and activities as part of the Town of Apex Parks, Recreation, and Cultural Resources Department's scheduled program and we have been requested to provide certain emergency and/or medicinal care for the treatment of certain conditions and/or the prevention of anaphylaxis in the event the child comes into contact with a certain allergen(s), as described below. Please complete Part I of this document. This document will be provided to the required staff at the Town of Apex so it may assist with the distribution of medication and/or allergy care and needs of your patient during their participation in this program. If you need to provide further instructions or clarifications, please do so on a separate sheet of paper.

PART I: (To Be Completed By Physician)

Participant's Name: _____ Participants Birthdate: _____

Medicines

Please provide a list of all medications that the Participant must take during the day along with instructions as to administration including method, time of day, dosage, frequency and instructions as to how to proceed if a dosage is missed:

1. Medication: _____ Dosage: _____ Side effects: _____

Reason for Medication: _____ Times: _____

Instructions: _____ How Taken (By Mouth, Inhaled, Eye Drops): _____

Administered By: [ ] APR&CR Staff [ ] Self (Doctor's Permission Attached)

2. Medication: _____ Dosage: _____ Side effects: _____

Reason for Medication: _____ Times: _____

Instructions: _____ How Taken (By Mouth, Inhaled, Eye Drops): _____

Administered By: [ ] APR&CR Staff [ ] Self (Doctor's Permission Attached)

3. Medication: _____ Dosage: _____ Side effects: _____

Reason for Medication: _____ Times: _____

Instructions: _____ How Taken (By Mouth, Inhaled, Eye Drops): _____

Administered By: [ ] APR&CR Staff [ ] Self (Doctor's Permission Attached)

Allergens

Please provide a complete list of all events, foods, and/or substances that may trigger a severe allergic reaction in the child.

- ☐ Bee Sting
- ☐ Pollen
- ☐ Dust Mites
- ☐ Other Insect Bite(s) (Identify): _____
- ☐ Medicine(s) (Identify): _____
- ☐ Plants (Identify): _____
- ☐ Animal Fur (Identify): _____
- ☐ Food Allergy: (Identify All Foods That Must Be Avoided): _____
- ☐ Other: (Identify) _____

Symptoms

Please provide a complete list of all symptoms or events that indicate that the participant has come into contact with an allergen and that he or she requires emergency treatment.

- ☐ Shortness of Breath or Difficulty Breathing
- ☐ Coughing, Wheezing, or Difficulty Swallowing
- ☐ Swelling of the Face, Lips, Throat or Tongue
- ☐ Hives or Welts
- ☐ Itching/Redness
- ☐ Vomiting, Nausea, Abdominal Pain, Diarrhea
- ☐ Dizziness, Fainting
- ☐ Other (Explain): _____
- ☐ Do Not Administer Medication in the Absence of Known Exposure to Allergen. (Explain): _____ _____

Procedures

Please identify what steps should be taken in the event of an allergic reaction and the order in which they should be executed. (Please place a number in the blank or an "N/A" if not applicable)

_____ Give Benadryl Elixir - _____ml orally.
_____ Administer EpiPen or _____ Injection Site:_____
(Identify Device to Be Used)
_____ Call Medical Personnel ("911").
_____ Call parent(s)/Guardian(s), and Participant's Physician.
_____ Other (Explain):_____

Program Activities

1. The Child May Participate in Recreational Activities and Other Programs Administered by the Town of Apex PR&CR Department. Yes [ ] No [ ]
2. Activity Restrictions: None [ ] Some Restrictions [ ]

If There Are Restrictions, Explain: _____

_____

Physician

Name:_____ Telephone Number: _____

Address: _____ Emergency Contact Number: _____

Signature: _____ Date: _____

PART II: (To Be Completed By Parent(s)/Guardian(s))

Name: _____ Address: _____

Telephone Number: _____Emergency Contact Number: _____

Medication Administration and Distribution Policies

1. You must fill out one "Authorization Form" and one "Release Form" per child and return it to the APR&CR office seven (7) calendar days prior to the program start date.
2. The Parent(s)/Guardian(s) are responsible for providing all medication in original containers displaying the name of the medication, expiration date, dosage amount, directions for administration and the participant's name. APR&CR staff will not distribute medication otherwise. It is the responsibility of the parent to ensure the child has the proper amount of medication.
3. Over the counter medications, vitamins, homeopathic remedies, and nutritional supplements will not be accepted unless they are scheduled for daily administration and accompanying a physician's prescription.
4. Parent(s)/Guardian(s) agree to bring the medication to the program or event site and provide it directly to the appropriate APR&CR staff member. As a safety precaution, the child will not be allowed to bring in or take home medication. Medication should never be in the child's possession unless medication is dispensed on their person or a doctor has specifically indicated in writing that the child may self-administer and safety precautions are met for the safe handling of the medication. If a doctor has given this written permission, a copy must be provided to the APR&CR.
5. Parent(s)/Guardian(s) also agree to pick up the medication at the end of each day and acknowledge that medication that is not picked up within 5 days after being provided to Parks and Recreation staff will be turned over to the Apex Police Department to be discarded consistent with their standard procedure.
6. If the child is taking medication at two different program sites, parents must supply medication for both sites. Medication will NOT be transported between programs by APR&CR Staff.
7. Parent(s)/Guardian(s) will notify staff any time there are changes to the medication or instructions for the administration of the medication.
8. The APR&CR staff has my permission to administer the above medication to my child.

By signing this form, I\We authorize the Town of Apex, its employees, agents, and volunteers, to follow the above instructions in this Authorization Form and to distribute and/or release the information in this form, or any other medical information obtained, as needed for the treatment of my/our child. I/We agree to update this form whenever my/our child's needs change.

Signature: _____ Date: _____

Signature: _____ Date: _____