



Allergy / Medical Condition Information Form

(only required if participant has an allergy or medical condition)

Participant's Name: _____ Date: _____

Parent/Guardian's Name(s): _____

Address: _____

Phone (*primary*): _____ Phone (*secondary*): _____

Participant's Medical Condition/Allergy: _____

Participant's history with condition. Please include known triggers as well as what an episode or allergic reaction looks like: _____

If the participant takes medication for this condition/allergic reaction, please detail the specific medication administration instructions (*see example below*):

1. _____
2. _____
3. _____

Special Notes: _____

Example:

1. *If participant comes in contact with a peanut product, give Benadryl as noted on Assisted Administration of Medication Form immediately. Call parent as soon as medication is given.*
2. *Observe participant for 5 minutes. If the lips swell or the participant continues to show symptoms of an allergic reaction, administer the EpiPen. Begin timing for second set of 5 minutes.*
3. *Call EMS as soon as EpiPen is administered and observe the participant.*

Special Notes: *This is a SEVERE allergy. If symptoms persist and EMS does not arrive in 5 minutes, administer the 2nd EpiPen.*

Please Continue to the Following Page

Permission Form for Assisted Administration of Medication

Carolina Beach Parks and Recreation Staff only administer medication to participants if:

- The Town of Carolina Beach Permission Form for Assisted Administration of Medication is completed and in the possession of the Carolina Beach Parks and Recreation (CBPR) Staff.
- A CBPR Staff will not give medications unless it is in an original container with appropriate medicine contained within, with a visible label including the name of the medication, the date of expiration, clear dosage amount and directions with the participant's name clearly indicated on the bottle/box.

The Parent/Guardian is responsible for the following with ALL medication:

- Complete and sign the portion of the form below and return to the Carolina Beach Parks and Recreation Department. Staff will complete the bottom section in gray.
- Provide medication in the original container with visible label including the name of the medication, the date of expiration, clear dosage amount and administration directions with the participant's name clearly indicated. Inhalers outside the original package must be accompanied by a copy of the original package label noting the above information.
- Provide new, labeled containers if/when medication changes are made.
- Parent/Guardians must transport medication to Carolina Beach Recreation Center and give directly to CBPR Staff.
- Parent/Guardian must pick up medication at the end of each week from CBPR Staff. Medications not picked up at the end of 14 business days following the last day of participation in the program will be disposed of by Staff.
- The pharmacy label will serve as the physician's authorization for the medication to be administered.
- If the medication is an EpiPen or inhaler, it is recommended (*not required*) that the pharmacist label two containers to keep at the program site (*so parent/guardian can transport medication daily*). The parent/guardian should check to ensure the medication does not exceed the printed expiration date. Staff will not accept expired medication.
- Parents/Guardians should notify Staff in writing as soon as possible if there are any changes to instructions for the administration of medication once this form is submitted. A new form may be required.

By completing the information below, the Carolina Beach Parks and Recreation Department Staff is authorized to administer any medication(s) that are provided as indicated above. Staff will complete the bottom section in gray.

Participant's Name: _____

Name of Medication: _____ Dosage: _____

Reason for Medication: _____ Times: _____

Side Effects: _____

Parent/Guardian's Name: _____ Date: _____

Parent/Guardian's Signature: _____

For Carolina Beach Parks and Recreation Staff Only

Quantity Provided: _____ Staff Initials & Date: _____