MEDICATION ADMINISTRATION REQUEST AND AUTHORIZATION FORM

Participant's Last Name ____

First Name ____

Program Registered for ____

The following guidelines below must be followed when bringing medication to a Plano Parks and Recreation program.

1. For participant safety, all medication, prescription or over the counter, must be brought to the Parks and Recreation staff member overseeing the program by the parent. Medications are not provided by the Parks and Recreation Department.

2. All medication, prescription or over the counter, must be in its original, properly labeled container and will only be administered according to the labeled instructions or a medical order.

3. Only medication that cannot be given at home will be given during program hours.

4. Only a one day supply of medication will be accepted each day. This form will be kept on file for use with subsequent days' doses.

5. Medication that has expired will not be administered.

7. Aspirin or products containing aspirin will not be given without a physician's order.

Medication____

Prescription Number____________________________________

Dosage_____________________

Time_______________________

Will this be the first dose of a new medication for your child _____Yes _____No

Expiration Date ______________________________________

Special instructions / precautions / side effects of this this medication for your child?

____

By my signature below, I affirm that it is impossible to schedule the above mentioned medication at a time other than during program hours. I request that this medication be given by Parks and Recreation staff. I acknowledge that I will not hold the Plano Parks and Recreation, City of Plano or its employees liable for damages or injuries resulting from administration of this medication (prescription / nonprescription / homeopathic / over the counter).

By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury.

Parent Signature____ Date_________________

Parent Printed Name____

Phone Number__________________________________

E-mail Address__________________________________

Name of Participant's Physician_______________________________

Phone Number __________________________________