MEDICAL ADMINISTRATION FORM

Child(ren)'s Information:

Full Name: _____ Gender (Please Circle) M F

Age: _____ Birth Date: _____ Health Card Number: _____

Doctor's name & Phone Number: _____

Special Medical Information (eg. Hearing disorder, diabetes, vision impairment, epilepsy, learning disorders):

_____
_____
_____
_____
_____

Allergies (list severity & intervention required):

_____
_____
_____
_____
_____

EMERGENCY MEDICAL TREATMENT

In the event of an accident or illness involving my child while attending the program I hereby authorize, Camp Facilitators or the Recreation Programmer to assist in the administering of all medication that is provided by the parents and/or guardians. Under no circumstances shall medication be provided without written or verbal consent from the master contact.

If an ambulance is called due to the severity of an allergic reaction/ anaphylaxis reaction, I understand that the billing for the ambulance will be forwarded to the master contact specified on the registration form. ☐ YES ☐ NO

I understand that;

1. As the parent/guardian of the named camper, that I request and authorize the oral administration to said camper of the prescribed medication referred to below, using procedures outlined below, by the Day Camp Coordinator or Recreation Programmer, who I acknowledge are not medically trained to administer medication.

2. I understand that no more than the prescribed dosage is to be sent to camp.
3. I understand and accept that if questions arise about administering the medication, the Recreation Programmer or his/her designate, will contact the dispensing pharmacy to clarify the issue; for example, (including without limitation) whether there is a need to give the medication on an empty or full stomach.
4. I also understand and accept that if problems arise with the administration of the medications; for example, (including without limitations) refusal of medication by the camper to take medication, complaints of side effects, or possible allergic reaction, then the camp will immediately discontinue further doses and inform the parent/guardian's at the earliest practical opportunity, as to the nature of the problem. It is then the parent/guardians responsibility to decide if the camper's physician needs to be consulted to assess whether changes to the prescribed medication need and/or administration procedures referred to below are necessary. A new copy of this Medical Administration form are required for any changes made.
5. I also understand and accept that the Recreation Programmer can reserve the right to refuse to administer treatment to the camper if the necessary information is not provided by the parent/guardian.
6. I confirm that I have asked the camper's physician if the medication must be administered during camp hours and he/she has advised so.
7. The information gathered in this form is collected pursuant to the Municipal Freedom of Information and Protection of Privacy Act.
8. This information will be used to assist with the meeting of the health needs of camper.
9. If there are any questions about the information gathered on this form, please contact the Recreation Programmer.
10. This request will terminate Labour Day Monday of each year.
11. I hereby release the Township of Wilmot, it's employees and agents from all manner of action, causes of action, suits, losses, damages, or injuries, however caused, arising out of the administration or failure to administer medications as provided herein, and I do also hereby indemnify the Township of Wilmot, it's employees and agents for any losses or damages sustained by them as a result of such actions or proceedings being commenced again them by myself or the camp or any other parent or guardian of said camper.
12. I hereby acknowledge that I have read and fully understand the terms set out herein.

Administration Instructions and where to find medication (please specify for **each type of medication**):

_____
_____
_____
_____
_____
_____
_____
_____

MEDICATION INFORMATION: TO BE COMPLETED BY PARENT/GUARDIAM

Diagnosis/ reason for medication:

Medication(s) Prescribed	Dosage	Time of Administration
1.		
2.		
3.		

Possible side effects (if any):

Duration of continuing medication:

Master Contacts Name: _____ Date: _____

Master Contacts Signature: _____ Date: _____

OFFICE USE ONLY

To the extent that the foregoing information constitutes personal information under the Municipal Freedom of Information and Protection of Privacy Act, 1989, the information is collected under the authority delegated to the Township of Wilmot by virtue of the Revised Statutes of Ontario and will be used for the purposes indicated or implied by this form. Questions about the collection of personal information should be directed to The Clerk's Department, The Corporation of the Township of Wilmot, 60 Snyder's Road, Baden, Ontario, N3A 1A1. 519-634-8444.

All questions about the medication listed above have been answered to the satisfaction level of the Recreation Programmer.

Recreation Programmer:_____ Date:_____