Health/Medication Form

General Information

Name of Participant:_____ Birth Date:_____

Medication

Participants may self-administer a prescription, including emergency medical devices, and over the counter medications during program hours. Individuals must be able to name and recognize their medication, and know the proper dosage and how to administer. The first dose of any new medication must be taken 24 hours prior to attending a Phillips Wharf program. All medications must be in the original pharmaceutical container, including asthma inhalers. Program staff will verify in writing the amount of medications they have accepted for a participant.

Name of Medication(s) (includes emergency devices):_____
Reason for medication(s):_____
Medication dosage:_____
Directions for medication(s):_____
Possible side-effects for medication(s):_____

☐ MEDICATION TAKEN AT HOME Parent Signature:_____Date:_____
☐ MEDICATION DURING PROGRAM HOURS -
A **physician** must complete and sign this section if a participant is taking medication, including emergency medical devices, DURING PROGRAM HOURS

Physician Signature:_____
Physician Name (printed):_____
Physician Address:_____
Physician Phone Number:_____Date:_____

Waiver to Carry Emergency Medical Device

All emergency medical devices (i.e. inhalers and EpiPens) must be carried on the participant's person at all times while attending Phillips Wharf programs. This section must be completed by a parent/guardian.

Due to the potential necessity for immediate medication distribution imposed by my child's life-threatening condition, I _____ hereby request that _____ be allowed to keep the appropriate prescribed device(s) on his/her person while participating in all Phillips Wharf programs.

The prescribed device is a:

☐ Inhaler ☐ EpiPen ☐Other_____

Allergy/Other Information

Does the individual have any allergies staff should be aware of?

☐ None ☐ Food ☐Medication ☐Environmental (pollen, poison ivy, etc.)

Describe Allergy: _____

Reaction Level: _____Mild _____Moderate _____Severe

Required Treatment:_____

Are there any health concerns staff should be aware of?

☐No

☐ Yes – Please Explain: _____

_____

Are there any physical, psychiatric, behavioral, emotional, or developmental concerns staff should be aware of?

☐No

☐ Yes – Please Explain: _____

_____

Release Authorization

I hereby represent and warrant that the information pertaining to the individual listed above is correct. I am authorized to provide the waiver, medical information, and release authorization contained herein and agree to Phillips Wharf Environmental Center policies as stated above. I understand that Phillips Wharf staff are certified in CPR/First Aid and give consent for them to administer CPR/First Aid to my child should the need arise. I agree to release Phillips Wharf Environmental Center and its agents from any and all liability arising as a result of this waiver.

_____

Printed Name (parent/guardian if under 18) *Signature* *Date*