Camper's Name:

Request for Administration of Medication Form

Please complete the following form for each medication to be administered to you (or your child/ward) during a Cleveland Metroparks program. (This form only needs to be completed by adults if they need assistance from Cleveland Metroparks with administering medication during a program; it doesn't need to be completed for self-administration by adults).

Please note that all medications, whether prescription or nonprescription:

- must be in the original container,
    - For prescriptions, this includes: the minor's full name, name of medication, a current dispensing date (within previous 12 months), medication expiration date, dosage of medication to be given, frequency of dosage, route and/or manner of administration, and the name of the prescribing physician.
- must not be beyond the expiration date identified on the container, and
- must be labeled with your child's name, either on the container or in a labeled Ziplock bag.
- If medication must be measured out, a device that allows proper measurement, such as a cup or dropper marked in the unit of measurement consistent with the dosing instructions must be provided.

You must certify that the dose of medication to be provided by Cleveland Metroparks is not the first dose of the medication to be given to you (or your child/ward).

Cleveland Metroparks will not give medication in a manner inconsistent with this form. If the dosage of your (or your child's/ward's) medication changes, you must complete a new Request for Administration of Medication Form and submit it to Cleveland Metroparks. A new form is needed for every program in which you (your child/ward) are/is enrolled.

If you (or your child/ward) has medical needs beyond those addressed by this form, please contact Cleveland Metroparks, and Cleveland Metroparks will work with you to accommodate your (your child's/ward's) needs.

Box 1: Must <u>ALWAYS</u> be completed by adult participant or parent/guardian

Box 1: Adult participant or Parent/Guardian Instructions – use one form per medication/product.

(Check all that apply):

◯ Nonprescription medication (including topical medications)*

I give permission for my child (school-aged and older) to keep his/her non-prescription topical medication with him/her during the program: ◯ Yes ◯ No

I give permission for my child (15 years or older) to keep his/her non-prescription medication with him/her during the program assuming he/she confirms dosage with Cleveland Metroparks staff and he/she doesn't share medication with others: ◯ Yes ◯ No

◯ Prescription medication (including topical medications)**

I give permission for my child (school-aged and older) to keep his/her emergency inhaler or epinephrine autoinjector) with him/her during the program: ◯ Yes ◯ No

◯ Food supplement

Camper's Name:

Complete all of the following information:

Name of Participant: _____ Birth Date: _____ Weight: _____

Name of Medication/Product: _____

Exact Dosage: _____Expiration Date: _____

Parents must also complete the outlined box below OR attach a doctor/school approved treatment/action plan.

◯ Completing outlined box below ◯ Attaching currently approved treatment/action plan

To be administered at the following time(s)/for following reasons if not time specific (epi*/inhalers):
_____

For the following dates: _____

Side effects of medication: _____

Additional notes staff administering should know: _____
_____

By signing below, I acknowledge that Cleveland Metroparks will administer the medication identified above to me (or my child/ward). I acknowledge there are risks associated with the administration of the medication to me (or my child/ward), and I agree to and do hereby waive any and all claims against, and agree to fully release, hold harmless, and indemnify, the Board of Park Commissioners of the Cleveland Metropolitan Park District, its officers, employees, agents, sponsors, and volunteers (the "Releasees") from any and all claims related to any illness, injury, death or loss of any description which I (or my child/ward) may sustain arising out of, or in any way associated with, provision of the medication, even though liability may arise out of the negligence or carelessness of the Releasees. I further confirm that the dose of the above medication to be given by Cleveland Metroparks is not the first dose of the medication given to me (or my child/ward).

X Signature of Adult Participant or Parent/Guardian _____ Date: _____

* Nonprescription medications can only be given with an adult participant's or parent's/guardian's signature if the dosage requested is the dosage prescribed on the medication container for your (or your child's/ward's) weight/age. If another dosage is requested, please complete Box 2.

** Prescription medications can only be given with adult participant's or parent's/guardian's signature if the dosage requested is the dosage identified on the prescription container. If another dosage is requested, please complete Box 2.

Box 2: Must ALWAYS be completed by a licensed physician, dentist, or nurse practitioner and the adult participant or parent/guardian.

Box 2: Instructions – use one form per medication/product.

(Check all that apply):

◯ Nonprescription medication to be given in a dose other than that prescribed on the medication container (including topical medications)

I give permission for my child (school-aged and older) to keep his/her non-prescription topical medication with him/her during the program: ◯ Yes ◯ No

I give permission for my child (15 years or older) to keep his/her non-prescription medication with him/her during the program assuming he/she confirms dosage with Cleveland Metroparks staff and he/she doesn't share medication with others: ◯ Yes ◯ No

◯ Prescription medication to be given in a dose other than that prescribed on prescription container (including topical medications)

I give permission for my child (school-aged and older) to keep his/her emergency inhaler or epinephrine autoinjector) with him/her during the program ◯ Yes ◯ No

Complete all of the following information:

Name of participant: _____ Birth Date: _____ Weight: _____

Name of Medication/Product: _____ Exact Dosage: _____

To be administered at the following time(s)/for following reasons if not time specific (epi*/inhalers):
_____

For the following dates: _____

Side effects of medication: _____

Additional notes staff administering should know: _____
_____

X Signature of Physician _____ Date: _____

By signing below, I acknowledge that Cleveland Metroparks will administer the medication identified above to me (or my child/ward). I acknowledge there are risks associated with the administration of the medication to me (or my child/ward), and I agree to and do hereby waive any and all claims against, and agree to fully release, hold harmless, and indemnify, the Board of Park Commissioners of the Cleveland Metropolitan Park District, its officers, employees, agents, sponsors, and volunteers (the "Releasees") from any and all claims related to any illness, injury, death or loss of any description which me (or my child/ward) may sustain arising out of, or in any way associated with, provision of the medication, even though liability may arise out of the negligence or carelessness of the Releasees. I further confirm that the dose of the above medication to be given by Cleveland Metroparks is not the first dose of the medication given to me (or my child/ward).

X Signature of Adult Participant or Parent/Guardian _____ Date: _____

*For Epinephrine via autoinjectors, the minor's prescribing physician must have provided:

1. The minor's name and address;
2. The name and dose of the medication contained in the autoinjector;
3. The date the administration of the medication is to begin;
4. The date, if known, that the administration of the medication is to cease;
5. If the minor is to use her/his own autoinjector, acknowledgement that the physician has determined the minor is capable of possessing and using the autoinjector appropriately and provided the minor with training in the proper use of the autoinjector;
6. Written instructions that outline procedures Cleveland Metroparks staff should follow if the minor is not capable of possessing and/or using the autoinjector;
7. Circumstances in which the autoinjector is to be used;
8. Written instructions that outline the procedure if the autoinjector does not produce the expected relief from the minor's anaphylaxis;
9. Any severe adverse reactions that may occur to another minor, for whom the autoinjector is not prescribed, should such minor receive a dose of the medication;
10. At least one telephone number for contacting the physician or her/his designee in the case of an emergency;
11. Any other special instructions from the physician.

A backup dose of the medication should be provided to Cleveland Metroparks staff (2 autoinjectors).

Box 3: For Camp staff use only.

Name of Participant: _____ Birth Date: _____

Medication given: _____

Date	Time	Dosage	Printed Name of Person Administering Medication	Signature of Person Administering Medication