**Brentwood Recreation Department**

**Medical Treatment & Medical Authorization Form**

**Town of Brentwood Recreation Department**

**1 Dalton Rd. Brentwood, NH 03833**

**603-642-6400 ext. 120**

EMERGENCY MEDICAL TREATMENT AUTHORIZATION OR REFUSAL

In the event I, cannot be reached in an emergency requiring medical treatment for my child, , I hereby give my consent to employees of the Brentwood Recreation Department to secure proper emergency treatment and transportation of my child as deemed necessary.

The Brentwood Recreation Department requires the following information regarding medication needs of participants in Brentwood Recreation programs. Please note the following policies:

1. Each medication (i.e. prescription and over the counter) to be taken or medical devices/procedures/inhalers/Epi-pens) used during program hours will remain the child’s possession to be placed in the same location of child’s backpack each day.
2. Camp staff is not authorized to administer medication. They will remind and supervise the taking of medication for the participant and medication listed below.
3. Parents/Guardians are solely responsible for ensuring the adequate medication is provided in a secured contained labeled with your child’s name, the name of the medication, the dosage amount, and the time or times to be taken.
4. Medical personnel are not provided at our programs.

Participant Name:

Name of Medication # 1:

 Dosage Amount of Medication # 1:

Frequency of Dosage for Medication # 1:

Time(s) to be taken during program hours:

Duration of treatment:

Possible side effects and adverse reactions (if any):

Other Information:

Health Care Prescriber: Phone #:

Name of Medication # 2:

 Dosage Amount of Medication # 1:

Frequency of Dosage for Medication # 1:

Time(s) to be taken during program hours:

Duration of treatment:

Possible side effects and adverse reactions (if any):

Other Information:

Health Care Prescriber: Phone #:

Name of Medication # 3:

 Dosage Amount of Medication # 1:

Frequency of Dosage for Medication # 1:

Time(s) to be taken during program hours:

Duration of treatment:

Possible side effects and adverse reactions (if any):

Other Information:

Health Care Prescriber: Phone #:

Parent Signature: Date:

Parent’s Printed Name:

Cell Phone: Home Phone:

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| *Parent/Guardian Signature:*  | Date:  |
| Participant Name:  | Age:  |
| *Participant Signature:*  | Date:  |