Longmont Recreation Services Medical Release Form for Medicine

Parent's Request for Giving Medicine and Release Agreement and Physician's Signed Order

□ I do not wish to have my child given medication while at camp. _____ initials (go on to next form)

□ I, the undersigned parent or guardian of _____, hereby request personnel

employed by the City of Longmont Recreation Services to administer_____
(name of medicine)

at _____ to my child as described by the prescribing physician.
(time)

If there is a change in medication, times given, dosage, etc, the Director must be notified in writing.

The City of Longmont Recreation Services and the Boulder County Health Department require, as a condition before administering any medication that; the medication be prescribed by a physician or dentist, the medication be provided by the parent or guardian, the medication be correctly labeled with the child's name, the name of the medication, the times for the medication to be given, the correct dosage, possible side effects and instruction for treatment, and the date the medication is to be stopped. The medication is administered solely at the request of and as accommodation to the undersigned parent, guardian and child. The parents or guardians agree, in consideration for the administration of the medication, to release and hold harmless the City of Longmont, its employees and volunteers or the failure to administer or correctly administer the medication. Nothing in this agreement shall be deemed as a waiver of sovereign immunity or liability limits granted to the City under the Colorado Governmental Immunity Act, nor to confer upon any person not a party hereto, any rights or benefits hereunder.

DATED this _____ day of _____ 20____.

_____ _____
Name of Physician or Dentist Signature of Parent/ Guardian

Prescribing Medication _____

↘Required↘

PHYSICIAN'S SIGNED ORDER FOR MEDICINE GIVEN AT CAMP

Child's Name_____ Medication _____

Route of administration_____ Dosage _____

To be given at _____ from _____ to _____
(time) (date) (date)

Purpose of medicine _____

Possible side effects _____

_____ _____
Date Physician's Signature