100 John West Way
Aurora, Ontario
L4G 6J1
(905) 727-3123
aurora.ca

Town of Aurora

Participant Allergy & Medication Form

Community Programs Division

A – PARTICIPANT INFORMATION

Participant Name:	Parent/Guardian Name:
Emergency Contact Name & Phone #:	Parent/Guardian Phone #:

B - ALLERGY DESCRIPTION & INFORMATION

If the participant has an allergy, please complete the information below. If participant does not have an allergy, please proceed to **Section D: Medication Information & Consent for Dispensing**.

1. Allergen: _____ Is this an anaphylactic allergy? ☐ Yes ☐ No
   Does the participant require an EPI Pen/Auto Injector for this allergy? ☐ Yes ☐ No
   Preference for Auto Injector storage:
   ☐ Worn on camper at all times ☐ Worn on Town Staff at all times
   Does the participant require alternative medication for this allergy? ☐ Yes ☐ No ***(if Yes, please complete Section D: Medication Information & Consent for Dispensing)***
   Known Symptoms or Warning Signs (after 0-15 minutes of consumption/contact to allergen):
   _____
   _____
   _____
   Onset of allergic reaction is brought on by (check all that apply):
   ☐ Ingestion ☐ Touching It ☐ Smelling It ☐ Other: _____

2. Allergen: _____ Is this an anaphylactic allergy? ☐ Yes ☐ No
   Does the participant require an EPI Pen/Auto Injector for this allergy? ☐ Yes ☐ No
   Preference for Auto Injector storage:
   ☐ Worn on camper at all times ☐ Worn on Town Staff at all times
   Does the participant require alternative medication for this allergy? ☐ Yes ☐ No ***(if Yes, please complete Section D: Medication Information & Consent for Dispensing)***
   Known Symptoms or Warning Signs (after 0-15 minutes of consumption/contact to allergen):
   _____
   _____
   _____
   Onset of allergic reaction is brought on by (check all that apply):
   ☐ Ingestion ☐ Touching It ☐ Smelling It ☐ Other: _____

C - CONSENT FOR ADMINISTRATION OF AUTO-INJECTOR

☐ Yes ☐ No I authorize the Town of Aurora staff to administer medication by auto-injection to my child. I agree to release the Town, its employees and agents from all manner of actions, causes of action, losses, suits, damages or injuries whether caused by negligence or otherwise arising out of the administration or failure to administer the auto-injection as provided herein. It is my responsibility to ensure that it is not expired, that it is properly labelled with the child's name and the name of the medication, and that a medical doctor has authorized its use.

☐ Yes ☐ No I understand that the Town of Aurora recommends the daily drop-off and pick up of auto-injectors. I agree to ensure my child's auto-injector is brought to and picked up from programs daily.

☐ Yes ☐ No I understand The Town of Aurora cannot guarantee a risk free environment for my child but will take every reasonable precaution to mitigate this risk and limit exposure to the above stated allergens.

D – MEDICATION INFORMATION & CONSENT FOR DISPENSING

The Town of Aurora Community Services will provide supervision to participants who require the administration of medication during programs. The program participants are encouraged to accept the maximum responsibility for self-administering their medication. Town of Aurora Staff will dispense medication to the participant based on the information provided, and if needed based on ability of participants, will provide a hand-over-hand technique to aid in this process.

I agree to provide the daily prescribed dosage of medication in it's original container, containing the following information:

☐ **Child's Name**
☐ **Pharmacy Name & Phone Number**
☐ **Doctor's Name & Phone Number**
☐ **Name of Medication**
☐ **Dosage and Time to Administer Medication**

Name of Medication:	Prescribed Dosage:
Time to Dispense Medication:	Storage (ex. Fridge):
Instructions for dispensing medication:	Potential Side Effects of medication:

☐ Yes ☐ No I authorize the Town of Aurora to dispense the above listed medication to the participant.

☐ Yes ☐ No I agree to provide the daily–prescribed dosage of medication in it's original container along with the above information completed on this form to designated staff on a daily basis.

☐ Yes ☐ No I understand that the Town of Aurora recommends the daily drop-off and pick up of medications. I agree to ensure my child's medication is brought to and picked up from programs daily.

☐ Yes ☐ No I acknowledge that The Town of Aurora reserves the right not to administer medication in high-risk situations where the safety of staff and the participant could be jeopardized.

☐ Yes ☐ No I acknowledge that the employees or agents of The Town of Aurora are not medically trained to administer medication. I acknowledge that my child will be self-administering their own medication under the supervision of Town of Aurora program staff.

F – PARENT/GUARDIAN CONSENT & SIGNATURE

Personal information on this form is collected pursuant to the Municipal Freedom of Information and Protection of Privacy Act.

I hereby acknowledge and give consent for the recipient of this document to collect, use and disclose information included in this document regarding my child for the purpose of dispensing and administering medication and/or auto-injectors. I expressly consent to the exchange of this information with Town of Aurora Staff, Volunteers and partnering Service Agreement providers when reasonably necessary for the purpose of dispensing and administering medication and/or auto-injectors.

I/We hereby acknowledge that I have fully read and fully understand the terms set out herein, and sign this form on behalf of myself as the parent/guardian of the participant.

Name of Parent/Guardian_____ Date: _____

Signature of Parent/Guardian: _____