Appendix 4b

WAIVER & MEDICAL RELEASE FORM FOR MEDICATION – Epipen and Inhaler

Child/Youth's Name: ____ Age: _________

Address/Postal Code:____

Phone:____School:________________________________

What type of condition does your child/youth have to require medication? Please explain:

____

____

What type of medication is required?

____

Does this type of medication need to be administered by an adult or can it be administered by the child/youth?
Adult____ Child/Youth ____

Does a parent need to be contacted to administer the type of medication
YES____ NO ___

If yes please provide name and phone number of parent to be contacted:

Name:____ Home Phone:_____________________

Cell Phone:_____________________________ Work Number: _______________________________

If a leader can administer please fill out the information below:

I have trained ______________________________ to administer ______________________________ on my behalf.

Does your child/youth have any physical, emotional, mental or behavioral concerns or limitations that our staff should be aware of? YES _____________ NO _____________

If yes, please explain: ____

Precautions are taken for the safety and health of your child/youth, but in the event of accident or sickness, *BEMC*, its staff, and its volunteers are hereby released from any liability. In the event that your child/youth requires special medication, x-rays or treatment, the parents/guardians will be notified immediately.

Your child/youth must be covered by Provincial Health Insurance or equivalent medical insurance.

Provincial Health Insurance Number: ____

Name of Family Physician:_____________________ Physician's Phone Number: ___________

Parent/Guardian's Signature: **Date:**

____ __________________________