Barrington Recreation Department
105 Ramsdell Ln. Barrington, NH 03825
603-664-5224

Medical Authorization Form

Emergency Medical Treatment Authorization or Refusal

In the event I, _____ cannot be reached in an emergency requiring medical attention for my child, _____, I hereby give my consent to employees of the Barrington Recreation Department to secure proper emergency treatment and transportation of my child as deemed necessary. _____ *(Parent/Guardian initials)*

The Barrington Recreation Department requires the following information regarding medication needs of participant in Barrington 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 MUST be provided to the Recreation Department prior to the start of each program and will remain in the Department's possession for the duration of the program.
2. Camp staff are not authorized to administer non-emergency medication. They will remind and supervise the taking of medication for the participant and medication(s) listed below.
3. Parents/Guardians are solely responsible for ensuring that adequate medication is provided in a secured container 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: _____

Allergies: _____

Name of Medication # 1: _____
Purpose of medication: _____
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 #: _____

Include additional medication information on next page.

Name of Medication # 2: _____

Purpose of Medication: _____

Dosage Amount of Medication # 2: _____

Frequency of Dosage for Medication # 2: _____

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: _____

Purpose of Medication: _____

Dosage Amount of Medication # 3: _____

Frequency of Dosage for Medication # 3: _____

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: _____