

## West Bloomfield Parks and Recreation Commission

### Administration of Medications Policy

West Bloomfield Parks and Recreation Staff may store and/or administer medications for program participants under certain conditions:

- A "Permission to Administer Medication and Release of Claims" Form for each medication must be filled out and signed by the parent and doctor prescribing the medication.
- The "Permission to Administer Medication and Release of Claims" Form must be submitted to program staff prior to the beginning of the program session.
- Prescription medications allowed are oral and topical medications, inhalers, and epi-pens.
- Non-Prescription medications also require a completed "Permission to Administer Medication and Release of Claims" Form.
- The storage and/or administration of the medication by staff cannot be limited or prohibited by federal, state or local law or ordinance.
- Staff will not make any dosage decisions for any medication administration.

### Parent Responsibilities

- It is the parent's responsibility to inform program staff upon registration that their child takes medications, and that staff will be requested to administer that medication.
- "Permission to Administer Medication and Release of Claims" Forms are required to be completely filled out with all requested information and signed by the parent and physician before the program or camp begins.
- A "Permission to Administer Medication and Release of Claims" Form is needed for each medication to be administered.
- Medications must be in their original container and clearly labeled.
- Expired medications will not be accepted.
- Medications are to be given to program staff by the parent, not the child.

### Staff Responsibilities

- Program staff will be trained in first aid and in the administration of epi-pen medications.
- All medications will be kept in a secure location only accessible to program staff.
- All unused medication will be returned to the parent.
- Staff will keep accurate documentation of all medications administered by completing the proper paperwork which shall be kept in the programmer's files. Documentation shall include:
  - The date and time the medication was administered.
  - The dosage administered.
  - Signature of staff person administering the medication.
  - Any comments.
- Parents will be notified if/when a child has been administered medications.
- Parents will be notified immediately of any administration errors by telephone and in writing.

# WEST BLOOMFIELD PARKS AND RECREATION COMMISSION

## PERMISSION TO ADMINISTER MEDICATION AND RELEASE OF CLAIMS

Both pages must be completed and submitted to West Bloomfield Parks, with physician signature and date.

Participant Name: \_\_\_\_\_

Parent or Legal Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_

In case of emergency, who should Staff notify?

1. Name: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_

2. Name: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_

### TO BE COMPLETED AND SIGNED BY PHYSICIAN

Attending Physician (Please Print): \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

#### Medication

Name of Medication \_\_\_\_\_ Dosage: \_\_\_\_\_

Time of Administration; \_\_\_\_\_ Reason for Medication: \_\_\_\_\_

Comments/Possible Side-Effects: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SIGNED AND DATED WRITTEN INSTRUCTIONS OF A PHYSICIAN, PHYSICIAN'S ASSISTANT OR NURSE PRACTITIONER DESCRIBING THE PROPER ADMINISTRATION OF THE MEDICATION(S) MUST BE ATTACHED TO THIS FORM.

To be completed by parent or guardian:

I hereby request that the participant be administered prescribed medication during the time he or she is attending a program conducted by the West Bloomfield Parks and Recreation Commission, I understand that the medication will be administered by personnel designated by the Commission. I understand that the medication will be administered exactly as directed by the written instructions referenced above. I will notify the Commission of changes in the medication(s) by completing a new form. Also, I will inform the Commission of discontinuance of the medication(s) by written notice.

I acknowledge that the Commission owes no duty to the participant regarding his or her health or physical well-being and that any health information provided by me to the Commission has been voluntary and I expressly authorize the Commission to use this information for medical purposes. I authorize the Commission or any of its employees or agents to obtain medical care for the participant as deemed appropriate by the Commission. Any expenses incurred by the Commission on my behalf are my responsibility.

In consideration for participation in a program conducted by the Commission, I waive any rights I, the participant, or any family member may have against the Commission, the Charter Township of West Bloomfield, their appointed and elected officials, employees, volunteers, attorneys, assigns, agents and successors concerning the administering of the above designated medication(s). I release and discharge the Commission, the Charter Township of West Bloomfield, their appointed and elected officials, employees, volunteers, attorneys, assigns, agents and successors of and from all claims, debts, attorney fees, costs, actions and causes of action of any kind connected with the administering of this medication(s).

I have read and understand the West Bloomfield Parks and Recreation Commission Administration of Medication Policy and the contents of this form and sign this form voluntarily and knowingly.

Date: \_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian (Print Name)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship