AUTHORIZATION FOR SUNBLOCK, INSECT REPELLENT AND MEDICATION

Release and Indemnification Agreement

I hereby authorize the City of Staunton Department of Parks and Recreation Camp Staunton personnel to give the medication as directed by this authorization. I, on behalf of myself, my executors, administrators, heirs, next of kin, and successors, hereby covenant to hold harmless and indemnify the City and all of its officers, departments, agencies, agents and employees from any and all claims, losses, damages, injuries, fines, penalties and costs (including court costs and attorney's fees), charges, liabilities, or exposures, however caused, resulting from, arising out of, or in any way connected to assisting this participant with the use of medication. I have read and understand this HOLD HARMLESS AGREEMENT and by my signature agree to its terms.

PART I – To be completed by PARENT OR GUARDIAN

Camper Name: _____ Date of Birth: _____

Camper's site: _____

Parent/Guardian Signature: Daytime Phone #:

PART II – SUNSCREEN/INSECT REPELLANT – To be completed by PARENT OR GUARDIAN- MUST BE LABELED WITH CHILD'S NAME

Staff can apply the following to the program participant:

Sunblock ○ List adverse reactions (if any): _____

Insect Repellent ○ List adverse reactions (if any): _____

PART III – SHORT TERM MEDICATION – To be completed by PARENT OR GUARDIAN for medication that the participant is taking for up to 10 days. Examples include Tylenol or other analgesics, antibiotics or other medications that have been prescribed for a short term.

Diagnosis: _____ Prescription: _____

Dosage to be given at program: _____ Time to be given at program: _____

Start Dates - From: _____ To: _____

PART IV – LONG TERM MEDICATION – To be completed by the PHYSICIAN for medication that the child takes on a permanent or long-term basis. It is encouraged for parents to administer medication before or after the program if possible. Examples include inhalers, EpiPen's, insulin, or any other treatment for a long term disability or condition.

Diagnosis or reason for prescription(s) _____

If the child is taking more than one medication at the program, please list all of the medications below.

Medication Name	Dosage	Time	Dates to be administered	Special Notes

_____ _____

Physician Name (Print or Type) **Physician Signature** **Date**

Reminder to Parent/Guardian: Medication must be labeled with participant's name, name of medication, the dosage amount, and the time or times to be given. Medications must be in the original container with a single dose for the day (if applicable), and the prescription label or direction label attached.