Parks and Recreation
Administration of Medication and Health Care Provision Form

Section 1: TO BE COMPLETED BY PARENT/GUARDIAN

Name of Participant_____

Parents/Guardians_____

Address_____

Postal Code_____

Home Phone_____ Daytime Phone _____

Recreation Program__ _____

Emergency contact (other than parent/guardian listed above):

Name_____

Phone_____

I hereby request, authorize and empower the Halifax Regional Municipality, Parks & Recreation Department, to:

- ☐ administer, or supervise the administration of, medication;
- ☐ provide health care

to my child named above, as described in Section 2.

I hereby release the Halifax Regional Municipality, its Mayor, Councillors, Employees, Volunteers and Agents from and against all actions, claims or liability for any harm that may result from the administration of such medication or by the giving of such treatment to my child, including the personal injury or death of my child. I also agree to indemnify the Halifax Regional Municipality, its Mayor, Councillors, Employees, Volunteers and Agents against claims made on behalf of my child or by MSI or by any other person at any time arising out of the administration of medication or treatment as described herein. I acknowledge and understand that as a parent or guardian I am responsible to ensure there is medication in sufficient amount and dosage to meet the needs of my child every day my child participates in the program and requires the medication to be administered. I also understand and agree that if there is insufficient medication at the program location I will be contacted to make arrangements to transport new medication to the program location, or to make alternate arrangements for the care of my child for the remainder of the day. I hereby release the Halifax Regional Municipality, its staff members and volunteers, from any liability that may result from insufficient amounts of the medication being available at the program for administration to my child. I also understand that I am responsible for completing this form in the event that the prescribed medication, amount or frequency of dosage, handling or storage requirements change.
I have full and complete authority to authorize the administration of medication or provision of healthcare as herein described, and no other person's authorization is required. I agree to indemnify and save harmless the Halifax Regional Municipality against any liability incurred by the Halifax Regional Municipality where the medication is administered or the healthcare is provided as I have authorized, but where I have failed to disclose that another person's authorization was required.

_____ _____

Parent/Guardian's Name - Please Print Signature of Parent/Guardian

_____ _____

Witness Date

****Parents must complete an anaphylaxis action plan if applicable****

Form Revised June 2016

Municipal Government Act (MGA), the Halifax Regional Municipality is collecting personal information in order to support your child's participation in a Halifax Regional Municipality recreation program. This personal information will not be used or disclosed for any other purposes. If you have any questions about the collection and use of this information, please contact HRM's Access and Privacy Office at 490-4390 or accessandprivacy@halifax.ca.

Section 2: Medication and Health Care: TO BE COMPLETED BY PARENT OR GUARDIAN

Administration of Oral Medication

Medication must be provided in its original packaging, with the original dosing instructions from the pharmacy, and with the appropriate dosing tool.

Medical Condition requiring treatment_____

Medication Prescribed	Dose	Time(s) of administration	Staff or Child

Medical Condition requiring treatment_____

Medication Prescribed	Dose	Time(s) of administration	Staff or Child

Provision of Health Care

The Halifax Regional Municipality will not provide services such as, but not limited to: injection of medication (excludes epi-pen), catheterization, manual expression of the bladder or stomach, tube feeding, postural draining, or any services that require medical certification. For additional information, or if you have any questions, please contact _____

Medical Condition requiring treatment_____

Treatment Name	Dose	Time(s)	Duration of each treatment

Medical Condition requiring treatment_____

Treatment Name	Dose	Time(s)	Duration of each treatment

Special Considerations:

Possible side effects of medication/treatment:

_____
_____
_____

Type of storage required for medication:

_____
_____
_____

The administration of this medication or health care cannot be scheduled around the program and administered at home and that this administration by the Halifax Regional Municipality's Parks & Recreation staff and volunteers is necessary in order to permit my child to participate in the recreation program.

_____ _____

Date Signature of Parent/Guardian

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