Specialized Recreation and Inclusion Services
Trip Permission and Medication Form

Participant Name: _____ Phone Number: _____

Parent/Guardian Name: _____ Email: _____

Parent/Guardian Home Phone: _____ Cell Phone: _____

Emergency Contact for the trip: _____ Phone Number: _____

Please indicate the following for the participant listed above:

___ *Need staff to assist with medication administration **(must complete information in box below)**

___ Can self-medicate (staff will not assist with administration, but will provide verbal reminders)

You may list medication and times taken: _____

_____

___ Does not take medication

Please list any allergies: _____

***Permission Form for Assisted Administration of Medication**

1. Name of Medication: _____ _____ Prescription _____ Non-Prescription
   Dosage: _____ Times: _____
   Reason for medication: _____ Side effects: _____

2. Name of Medication: _____ _____ Prescription _____ Non-Prescription
   Dosage: _____ Times: _____
   Reason for medication: _____ Side effects: _____

3. Name of Medication: _____ _____ Prescription _____ Non-Prescription
   Dosage: _____ Times: _____
   Reason for medication: _____ Side effects: _____

4. Name of Medication: _____ _____ Prescription _____ Non-Prescription
   Dosage: _____ Times: _____
   Reason for medication: _____ Side effects: _____

5. Name of Medication: _____ _____ Prescription _____ Non-Prescription
   Dosage: _____ Times: _____
   Reason for medication: _____ Side effects: _____

****ONLY under special circumstances for NON-PRESCRIPTION medications (see #9 on back of form).**
Physician Name: _____ Signature: _____ Date: _____

By signing below, I authorize the above listed participant to travel with the City of Raleigh Specialized Recreation and Inclusion Services program to **all 2020 Spring Special Olympics competitions** from **February 1 – July 1, 2020**. I also have provided accurate information regarding medication and authorize City of Raleigh Services staff to provide the level of medication support as noted above and according to guidelines on the back of this form.

Parent/Guardian/Participant Signature: _____ Date: _____

Approved April 2014 (CEF)

City of Raleigh
Parks, Recreation and Cultural Resources Department (PRCR)
Medication Policy for Assisted Administration of Medication

***These guidelines only apply if *Need staff to assist with medication administration* is selected on the front of the form.**

Parks, Recreation and Cultural Resource employees only administer medication to participants if:

1. The City of Raleigh Permission Form for Assisted Administration of Medication (on front) is completed and in the possession of the PRCR staff.
2. A PRCR employee will not give medications unless it is in an original container with appropriate medicine contained within, with a visible label including the name of medication, the date of expiration, clear dosage amount and directions with the participant's name CLEARLY INDICATED on the bottle/box.

The Parent/Guardian is responsible for the following with ALL medication:

1. Complete and sign the portion of the form on the front of this page and return to the program staff.
2. Provide medication in an original container with visible label including the name of medication, the date of expiration, clear dosage amount and administration directions with the participant's name CLEARLY INDICATED. **Note:** Inhalers outside the original package, must be accompanied by a copy of the original package label noting the above information.
3. Provide new, labeled containers if/when medication changes are made.
4. Parents/Guardians must transport medication to program site and give directly to program staff.
5. Parent/Guardian must pick up medication at the end of each week/program from program staff. Medications not picked up at the end of 14 business days following the last day of participation in the program will be disposed of by program staff.
6. Recreation program employees will dispose of empty containers (unless otherwise instructed).
7. For Prescription medications: The pharmacy label will serve as the physician's authorization for the medication to be administered. Have the pharmacist label two containers: one for home use and one for use in the program, if the participant is to receive medication at both sites.
8. If the medication is an EPI pen or inhaler, it is recommended (not required) that the pharmacist label two containers to keep at the program site. The parent/guardian should check to ensure the medication does not exceed the printed expiration date. Program staff will not accept expired medication.
9. For Non-Prescription medications: The medication must be administered according to the dosage and administration instructions on the original container.
   **A physician's signature will be required as authorization IF medication is requested to be given in an alternate dosage, etc.
10. Parents/guardians should notify program staff as soon as possible if there are any changes to instructions for the administration of medication once this form has been submitted. A new form may be required.