Arlington Recreation Program
Medical Consent Form

Name of child: _____ Address: _____
Home Phone: _____ Birth Date:_____
Primary Contact Parent/Guardian: _____ Phone #1_____ Phone #2_____
Secondary Contact Parent/Guardian: _____ Phone #1_____ Phone #2_____
Emergency Contact Person: _____ Phone #1_____ Phone #2_____

Emergency Medical Treatment

I hereby give the Arlington Recreation Program permission to administer basic First Aid, CPR, and necessary medication to my child _____ and/or take my child _____ to a hospital and secure medical treatment when I cannot be reached or when delay could be dangerous to my child's health.

Allergies, Chronic Health Conditions

Allergies must also complete EAAP plan on reverse side of this sheet

Please list all of your child's allergies and/or chronic health conditions _____

_____

Medications

Please list medications that you will provide to ARP staff to administer in medical emergencies

_____

All medication should be in their original containers bearing the pharmacy label that shows the prescription number, date filled, physician's name, name of medication, direction for use and the patient's name.

Please provide detailed information on how to dispense medication(s) or medical treatment and protocol that ARP staff (Head Counselor or Director) should follow to dispense necessary medication or medical treatment in response to a medical emergency situation: _____

_____

_____

Parent Signature: _____ Date: _____

Note: Please be aware that in an emergency, ARSP staff will first contact 911 and secondly ensure contact with parent(s).

Emergency Allergy Action Plan (EAAP)

Name: _____ D.O.B. _____
Allergy: _____ Program/Location: _____
Asthmatic: Yes* _____ No _____ * Higher risk for severe reaction

Step #1 TREATMENT

Symptoms:	Give Checked Medication**	
If a food allergen has been ingested, but no symptoms	___EpiPen	___Antihistamine
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	___EpiPen	___Antihistamine
Skin: Hives, itchy rash, swelling of the face or extremetics	___EpiPen	___Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	___EpiPen	___Antihistamine
Throat* Tightening of throat, hoarseness, hacking cough	___EpiPen	___Antihistamine
Lung* Shortness of breath, repetitive coughing, wheezing	___EpiPen	___Antihistamine
Heart* Thready pulse, low blood pressure, fainting, pale, blueness	___EpiPen	___Antihistamine
Other* _____	___EpiPen	___Antihistamine

The severity of symptoms can quickly change. * Potentially life threatening.

Medical Dosage

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. (Use reverse side for instructions)

Antihistamine: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

Emergency Calls

1. Call 911 _____. State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Call Dr. _____ at _____.
3. Emergency contacts
   a. _____ 1. _____ 2. _____
   b. _____ 1. _____ 2. _____
   c. _____ 1. _____ 2. _____

Even if parent/guardian cannot be reached, DO NOT hesitate to medicate or take child to hospital! This information may be shared with appropriate Recreation Department Staff.

Parent/Guardian Signature: _____ Date: _____

Recreation Program Director Signature: _____ Date:_____