PARKS, RECREATION & COMMUNITY SERVICES DEPARTMENT
4117 OVERLAND AVE., CULVER CITY, CALIFORNIA 90230

(310) 253-6650
www.culvercity.org

AUTHORIZATION TO DISPENSE MEDICINE

I authorize the City of Culver City Staff to administer the following medicine(s) to my child:

Camper Name: _____

Name of Medicine(s): _____

Dosage: _____

At the following times: _____

Parent Name: _____

Parent Name (Print) and Signature: _____

Doctors Name, Signature or stamp: _____

Doctors Contact Information: _____

Medications that must be administered daily are the responsibility of the parent. The child must have on file with the Recreation Registration Office a "Medication Release" form signed by the parent specifically for the medication the child requires. Only over-the-counter medications such as Benadryl or topical solutions are allowed at camp; EpiPen or insulin is the responsibility of the parent to administer. No medication will be administered unless it is in a prescription container or original container with the child's name and specific dosage directions on it. The medicine must not be expired. Please do not allow your child to keep medications in their lunch box or backpack as these can easily get in the hands of other campers. All medications both over the counter and prescription must be turned in to staff and will be kept in the Camper Medication box inside of the Camp Director's office.

WAIVER AND CONSENT TO TREAT

CAMPER(S) NAMES: _____

ACTIVITY: _____

CONSENT TO MEDICAL TREATMENT OF MINOR

"In the event of sudden illness, accident or injury which may occur while said minor is engaged in an activity supervised by the City of Culver City – Parks, Recreation & Community Services Department and their representatives, agents or assignees, when neither parents, guardian or designated family physician can be contacted, I hereby give my consent pursuant to California Civil Code, s25.8, for emergency treatment as shall be necessary under the circumstances by any physician licensed under the Laws of the State of California."

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

Family Physician: _____ Telephone: _____

Medical Insurance Company: _____ Policy Number: _____

Emergency Contact:

1. Name: _____Phone: _____

2. Name: _____Phone: _____