

If any of the medications in the above list are to be given on an as-needed basis, please specify the symptoms/conditions when medication is to be taken and the frequency at which it may be given.

Name of Medication: _____

List of symptoms/conditions for which medication is to be administered:

Dose & Frequency: _____

If your child carries an epi-pen then parents/guardians must also fill out an epi-pen authorization form.

Parent/Guardian Name

Signature

Date

Physician's Name

Phone #

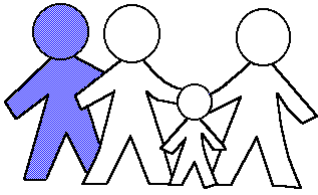
Date

PART III: To be Completed by Dr. Angela Fountain & Associates

This Authorization form is complete and medication is appropriately labeled.

Signature of Dr Angela Fountain & Associates Designee

Date



DR. ANGELA FOUNTAIN, C. Psych. & Associates

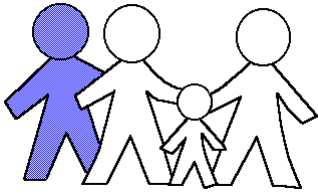
1037 Howden Rd. E., Oshawa, Ontario L1H 7K4

Tel: (905) 655-5813 Fax: (905) 635-1180

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PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. Medications should be administered at home whenever possible. All medications to be administered during program hours must have parent/guardian authorization. Some medications also require authorization by a physician (this includes over-the-counter, antibiotic, or antiviral medications that will be taken longer than 10 days or more then specified by the pharmaceutical manufacturer). The parent/guardian must transport the medication to the office and give it to designated staff.
2. The first dose of any new medication must be given at home to insure there are no negative side effects.
3. All medications must be properly labeled with the child's name, name of medication, exact dosage to be taken, expiration date and exact time or frequency dose is to be taken. The medication must be in the original container with the prescription label or direction label attached. The form and container must match. Make sure medication has not expired and will not expire during camp.
4. Medications may not be accepted by personnel unless the Authorization Form is completed and signed.
5. The parent/guardian is responsible for submitting a new form each time there is a change in dosage or a change in time which medication is to be administered.
6. All medication is kept in a locked area only accessible to authorized staff.
7. When an authorization for medication expires, the parent/guardian shall be notified that the medication needs to be picked up within 14 days. Any medications that are not picked up by the parent within 14 days will be destroyed.
8. Dr. Angela Fountain & Associates does not assume responsibility for unauthorized medication taken independently by the child.
9. Under no circumstances may any staff member facilitate the taking of any medications outside the procedures outlined here.



DR. ANGELA FOUNTAIN, C. Psych. & Associates

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EPI-PEN AUTHORIZATION

PART I: To be Completed by the Parent/Guardian

I hereby authorize Dr. Angela Fountain & Associates to administer Epinephrine injection as directed by the Physician below (Part II). I agree to release, indemnify, and hold harmless Dr. Angela Fountain & Associates from lawsuit, claims, expense, demand, or action against them for administering the injection, provided they follow the Physician's order as written below. I am aware that the injection may be administered by a specifically trained non-health professional. I have read the procedures outlined on the back of this form and I assume responsibilities as required. I understand that the rescue squad will always be called when Epinephrine is injected, whether or not the child manifests any symptoms of anaphylaxis.

Child's Name _____ DOB _____

Parent's Signature

Daytime Telephone

Date

PART II: To be Completed by Physician

Emergency injections will be administered by non-health professionals. For this reason, only pre-measured doses of Epinephrine may be given. It should be noted that Dr. Angela Fountain & Associates are not trained observers; therefore, they cannot observe for the development of symptoms before administering the injection. The following injection will be given immediately after report of exposure to:

Indicate specific allergen and type of exposure (i.e. ingestion, skin contact, inhalation)

Check as appropriate: *medication expiration date must be clearly indicated

Epi-Pen

____ Give the pre-measured dose by auto injection

____ Repeat dose in 15 minutes if rescue squad has not arrived (2 kits needed)

Please select one of the following:

- _____ I believe it is best for the program staff to carry the Epi-Pen on his/her person.
- _____ I believe this child can use the Epi-Pen properly in an emergency and this child may carry the Epi-Pen on his/her person.

Physician's Name and Number

Physician's Signature

Date

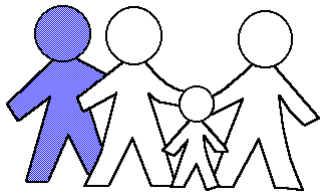
PART III: To be Completed by Dr. Angela Fountain & Associates

This form is complete and the medication is appropriately labeled.

The child _____ (has/ has not) been approved to carry own Epi-Pen.

Signature of Dr. Angela Fountain & Associates Designee

Date



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PARENT INFORMATION ABOUT EPINEPHRINE PROCEDURES

1. Epinephrine may only be administered with parent/guardian and physician authorizations. The parent/guardian must transport the Epi-Pen(s) to the office and give to designated staff.
2. Medication may not be accepted by personnel unless the Authorization Form is completed and signed.
3. A physician may use office stationery or prescription pad in lieu of completing Part II. Necessary information includes: child's name, allergen for which Epinephrine is being prescribed, type of exposure, brand name, amount of pre-measured epinephrine, time for repeat doses if deemed necessary, physician's signature and date.
4. The parent/guardian is responsible for submitting a new form whenever there is a change in dosage or a change in the conditions under which epinephrine is to be injected.
5. Only pre-measured doses of epinephrine may be given by Dr. Angela Fountain & Associates.
6. Medication must be properly labeled by pharmacist. Expiration date must be clearly indicated. Please make sure medication has not expired and will not expire during camp.
7. If repeat doses of Epi-pen injections are in the physician's order, the parent/guardian must supply two Epi-pen kits.
8. When an authorization for medication expires, the parent/guardian shall be notified that the medication needs to be picked up within 14 days. Any medications that are not picked up by the parent within 14 days will be destroyed.
9. Depending on the physician's order, Epi-Pens will be carried by the child or Dr. Angela Fountain & Associates.
10. Dr. Angela Fountain & Associates does not assume responsibility for unauthorized medication taken independently by the child.
11. Under no circumstances may any staff member facilitate the taking of any medications outside the procedures outlined here.