Physician's Authorization Form

PARKS, RECREATION, AND CULTURAL RESOURCES

AUTHORIZATION FOR EMERGENCY OR MEDICAL CARE FOR PARTICIPANTS WITH MEDICAL NEEDS OR SEVERE ALLERGIES

Physician: ______________________________ Date: ______________________

Your patient, ______________________________ will be participating in certain events and activities as part of the Town of Apex Parks, Recreation, and Cultural Resources Department's scheduled program and we have been requested to provide certain emergency and/or medicinal care for the treatment of certain conditions and/or the prevention of anaphylaxis in the event the child comes into contact with a certain allergen(s), as described below. Please complete Part I of this document. This document will be provided to the required staff at the Town of Apex so it may assist with the distribution of medication and/or allergy care and needs of your patient during their participation in this program. If you need to provide further instructions or clarifications, please do so on a separate sheet of paper.

(To Be Completed By Physician)

Participant's Name: ______________________________ Participants Birthdate: ______________________

Medicines

Please provide a list of all medications that the Participant must take during the day along with instructions as to administration including method, time of day, dosage, frequency and instructions as to how to proceed if a dosage is missed:

1. Medication: ______________________ Dosage: ____________ Side effects: ____________

Reason for Medication: ____________________ Times: ______________________________

Instructions: ______________________ How Taken (By Mouth, Inhaled, Eye Drops): ____________

Administered By: [ ] APR&CR Staff [ ] Self (Doctor's Permission Attached)

2. Medication: ______________________ Dosage: ____________ Side effects: ____________

Reason for Medication: ____________________ Times: ______________________________

Instructions: ______________________ How Taken (By Mouth, Inhaled, Eye Drops): ____________

Administered By: [ ] APR&CR Staff [ ] Self (Doctor's Permission Attached)

3. Medication: ______________________ Dosage: ____________ Side effects: ____________

Reason for Medication: ____________________ Times: ______________________________

Instructions: ______________________ How Taken (By Mouth, Inhaled, Eye Drops): ____________

Administered By: [ ] APR&CR Staff [ ] Self (Doctor's Permission Attached)

Allergens

Please provide a complete list of all events, foods, and/or substances that may trigger a severe allergic reaction in the child.

- ☐ Bee Sting
- ☐ Pollen
- ☐ Dust Mites
- ☐ Other Insect Bite(s) (Identify): ____________
- ☐ Medicine(s) (Identify): ____________
- ☐ Plants (Identify): ____________________
- ☐ Animal Fur (Identify): ____________________
- ☐ Food Allergy: (Identify All Foods That Must Be Avoided):

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- ☐ Other: (Identify) ____________________

Symptoms

Please provide a complete list of all symptoms or events that indicate that the participant has come into contact with an allergen and that he or she requires emergency treatment.

- ◻ Shortness of Breath or Difficulty Breathing
- ◻ Coughing, Wheezing, or Difficulty Swallowing
- ◻ Swelling of the Face, Lips, Throat or Tongue
- ◻ Hives or Welts
- ◻ Itching/Redness
- ◻ Vomiting, Nausea, Abdominal Pain, Diarrhea
- ◻ Dizziness, Fainting
- ◻ Other (Explain): ______________________________
- ◻ Do not Administer Medication in the Absence of Known Exposure to Allergen (Explain): ____

Procedures

Please identify what steps should be taken in the event of an allergic reaction and the order in which they should be executed. (Please place a number in the blank or an "N/A" if not applicable)

_____ Give Benadryl Elixir - ______ml orally.
_____ Administer EpiPen or ______________________________ Injection Site:______________________________
(Identify Device to Be Used)
_____ Call Medical Personnel ("911").
_____ Call parent(s)/Guardian(s), and Participant's Physician.
_____ Other (Explain):____

Program Activities

1. The Child May Participate in Recreational Activities and Other Programs Administered by the Town of Apex PR&CR Department. Yes [ ] No [ ]
2. Activity Restrictions: None [ ] Some Restrictions [ ]

If There Are Restrictions, Explain: ____

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Physician

Name:______________________________ Telephone Number: ______________________________

Address: ______________________________ Emergency Contact Number: ______________________________

Signature: ______________________________ Date: ______________________________