Consent For Administration Of Medication During Seizure

In the event that my camper is having a seizure lasting for more than _____
And is unable to administer the following medication, I/We hereby authorize and instruct the Town of Newmarket, its employees and agents to administer the following medication to my child:

Camper Information	
Child's Name:	
Date:	
Camp Attending:	
Week of Camp:	
Date of Birth:	
Health Card #:	

- Parent is to be contacted when any seizure occurs
- Parent is to be contacted when medication is required
- 911 is to be called when medication is administered
- 911 is to be called when _____

Description of Seizure Activity		
What Seizure looks like	Length of time	Action to be followed

Medication Information	
Medication Administered:	
Dosage:	
Administer When:	
Insturction for Administration	
Location and Storage of Medication:	

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Important - Read Before Signing

My/Our signature is the authority for the Town of Newmarket to administer seizure medication to my child. I/We hereby release the Town of Newmarket, its employees and agents from all manner of actions, causes of action, losses, suits, damages or injuries whether caused by negligence or otherwise arising out of the administration or failure to administer the seizure medication as provided herein. I/We also hereby indemnify the Town of Newmarket, its employees and agents for any losses or damages sustained by them as a result of such actions or proceedings being commenced against them by myself or my child. It is my/our responsibility to have my/our child carry the seizure medication, to ensure that it is not expired, that it is properly labelled with the child's name and the name of the medication, and that a medical doctor has authorized its use. Indicating on this form that I/we would prefer a different location for the seizure medication to be stored is my consent for the seizure medication to be stored in that area, and I/we hereby release the Town, its employees or agents for any losses or damages sustained resulting from the seizure medication being stored in that area.

I/We acknowledge that employees or agents of the Town of Newmarket are not medically trained to administer medication.

I/We realize that if attempts to contact an emergency contact fail, or the nature of the incident requires seizure medication, I/We hereby authorize program staff to act at their discretion for the safety of my child.

I/We hereby acknowledge that I have fully read and fully understand the terms set out herein, and sign this form on behalf of myself/ourselves, my/our child, and any other parent/guardian of this child.

Name: (18 Years or older)	
Signature: (Must be 18 years or older)	

Recreation & Culture – Camp Central
Town Of Newmarket, Recreation Youth Centre
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www.newmarket.ca Fax: 905-836-5125