Quarry Hill Nature Center
701 Silver Creek Rd. NE
Rochester, MN 55906
Phone: (507) 328-3950
Fax: (507) 287-1345

Epi-pen & Medication Authorization Form

must be renewed annually

To be filled out by parent or guardian

Child's Name: _____ Birthdate (m/d/y):_____

Emergency Contacts: (Place a 1 by the first to call, a 2 by the second to call, etc.)

___ Mother's Name_____ Home #_____ Work # _____Cell/pager # _____

___ Father's Name_____ Home #_____ Work # _____Cell/pager # _____

___ Other _____ Home #_____ Work # _____Cell/pager # _____

Allergies: _____

Asthmatic □ Yes □No

I, the undersigned parent of the above child, understand that medically trained personnel are not normally available at Quarry Hill Nature Center for the administration of prescription medication, including pills, fluid or drugs given via inhalers or epi-pens.

We are requesting Quarry Hill personnel be allowed, in an emergency, to administer the following medication to our child as prescribed by our physician.

Medication: **For the emergency treatment of:**

_____ _____

We understand that when medication is given by an injection, as with any injection, there are risks involved. We feel that the danger of delaying treatment of our child outweighs these risks and request the use of this medication despite the risks involved. **We also understand that it is Quarry Hill Nature Center policy to immediately call 911 once an epi-pen is administered.**

If Quarry Hill personnel are allowed to administer the medication described, we state that they are not liable to us or to our child for any injury, illness, death or disability caused by administrating, providing or injecting the prescribed medication. We hereby specifically release and hold harmless this person, their supervisors, and the Friends of Quarry Hill Nature Center, Inc., from any liability resulting from the administration or non-administration of the medication.

Parent /Guardian Signature: _____ Date: _____

To be filled out by physician (or) attach an anaphylaxis action plan from your physician.

I hereby prescribe the following medication to be administered during camp hours for the reasons stated:

Medication: _____ Dosage: _____

How often: _____ Route: _____

Diagnosis / reason for medication: _____

Physician's Signature: _____ Date: _____

Print Physician Name: _____

Clinic Name: _____ Phone Number: _____