

**BARRINGTON RECREATION DEPARTMENT  
MEDICAL TREATMENT & MEDICAL AUTHORIZATION FORM**

**Town of Barrington Recreation Department  
105 Ramsdell Ln. Barrington, NH 03825  
603-664-5224**

**Emergency Medical Treatment Authorization or Refusal**

In the event I, \_\_\_\_\_ cannot be reached in an emergency requiring medical attention for my child, \_\_\_\_\_, I hereby give my consent to employees of the Barrington Recreation Summer Camp to secure proper emergency treatment and transportation of my child as deemed necessary.

The Barrington Recreation Department requires the following information regarding medication needs of participant in the Barrington Summer Camp. Please note the following policies:

1. Each medication (i.e. prescription and over the counter) to be taken or medical devices/procedures/inhalers/Epi-pens used during cam program hours will remain in the child's possession to be placed in the same location of child's backpack each day.
2. Camp staff are not authorized to administer medication. They will remind and supervise the taking of medication for the participant and medication listed below.
3. Parents/Guardians are solely responsible for ensuring that adequate medication is provided in a secured container labeled with your child's name, the name of the medication, the dosage amount and the time or times to be taken.
4. Medical personnel are not provided at camp.

Participant Name: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dosage Amount: \_\_\_\_\_

Frequency of Dosage: \_\_\_\_\_

Time (s) to be taken during camp hours: \_\_\_\_\_

Duration of treatment: \_\_\_\_\_

Possible side effects and adverse reactions (if any): \_\_\_\_\_

Other recommendations: \_\_\_\_\_

Health Care Prescriber: \_\_\_\_\_ Phone #: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_