Town of Kennebunk  
Parks and Recreation Department

MEDICAL INFORMATION FORM & WAIVER POLICY

*Any childcare program participant with a medical condition or allergy is required to fill out this form.   
Please take the time to fill out this form thoroughly and accurately.*

Participant name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age & Grade (for summer camp, grade entering in the fall): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreation Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is a prescription needed during program hours? 󠄀󠄀 YES 󠄀󠄀 NO

….If yes, please fill out the following information regarding the prescription:

Prescription name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Administration time(s), dosage, and method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this form you are acknowledging the following policies:

* I understand that while my child will be supervised by an employee of the Town of Kennebunk, my child will be responsible for self-administering their prescription (with the exception of epi-pens, which would only be administered by staff) and I release the Town and its employees from any and all liability associated therewith.
* I understand that this is an important responsibility for my child, and by registering my child for a program and signing this form, I am acknowledging that they can handle this responsibility.
* I understand that I must hand-deliver medication to the Program Coordinator, and that this medication must be provided in its original container, and the child’s name, provider’s name, expiration date, and dosage information must be clearly visible and legible. Medications in any other container, including pill containers with past expiration dates, will not be accepted.
* I understand that Recreation Director and/or Program Coordinator will need to review and approve this form prior to medication being provided at any recreation program.

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

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Coordinator / Recreation Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of approval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_