CITY OF BLOOMINGTON MINNESOTA PARKS AND RECREATION

MEDICATION FORM

To be filled out by Parent or Guardian

CONFIDENTIAL

HH #: ____________________

★ Forms that were completed for your child's current school year with a physician signature may be submitted in addition to this form, and the physician signature on that form can be used in place of this form. ★

Completion of this form is required along with a parent or guardian signature

The City of Bloomington, Parks and Recreation intends to use the requested information to provide for your child's health and safety while at programming. You may refuse to supply the requested personal information. There will be no consequence for not providing the information. It may result in an incomplete health plan for your child. The information you provide will be shared only with staff in the program whose jobs require access to this information to ensure your child's safety.

Effective Year: ________________

PARTICIPANT

FIRST NAME:	**LAST NAME:**
BIRTH DATE:	___**Male** ___**Female**
HOME PHONE:	**CELL #:**

MEDICATION

MEDICATION:
Please list ONE

Will this be administered during program? Y / N

Condition for which prescribed:

Typical side effects of this medication:

Unusual side effects that may require action:

Dosage: Frequency: Intervals:

Additional instructions for use:

MEDICATION

MEDICATION:
Please list ONE

Will this be administered during program? Y / N

Condition for which prescribed:

Typical side effects of this medication:

Unusual side effects that may require action:

Dosage: Frequency: Intervals:

Additional instructions for use:

MEDICATION

MEDICATION:
Please list ONE

Will this be administered during program? Y / N

Condition for which prescribed:

Typical side effects of this medication:

Unusual side effects that may require action:

Dosage: Frequency: Intervals:

Additional instructions for use:

SIGNATURES REQUIRED →

CITY OF BLOOMINGTON MINNESOTA PARKS AND RECREATION

MEDICATION FORM

CONFIDENTIAL

Forms that were completed for your child's current school year with a physician signature may be submitted in addition to this form, and the physician signature on that form can be used in place of this form.
Completion of this form is required along with a parent or guardian signature

RETURN TO: City of Bloomington, Parks & Recreation, 1800 W. Old Shakopee Rd, Bloomington, MN 55431

Please do not forget the necessary signatures below.

The medications listed on the opposite side have been prescribed for the participant listed and I request that the Recreation staff administer any dosage falling during programming time.

Effective Year: _____

Physician Signature: **Date:**
Only necessary if medication or treatment needed at program

Form Completed by:

Relationship to Participant:

Date: **Phone:**

The Data Practices Act requires that we inform you or your rights about the private data we are requesting on this form. Private data is available to you, but not to the public. This information can be shared with the Bloomington Parks and Recreation staff. You can withhold this data, but you may not receive updated program information and/or accommodations. Your signature on this form indicates you understand these rights.

Signature of legal guardian REQUIRED

SIGNATURE: _____ **DATE:** _____

OFFICE ONLY:	Received on _____ (date) by _____(Staff)	
	RecTrac updated? Y / N	Plan Created? Y / N
	Parent/Guardian contacted? Y / N	P/G contacted on _____ (date)

Community Services Department Parks and Recreation Division, 1800 W. Old Shakopee Road, Bloomington, MN 55431-3027
PH 952-563-8877 FAX 952-563-8715 TTY 952-563-8740
parksrec@bloomingtonmn.gov BloomingtonMN.gov