

ATTENTION PARENTS

Each 4-H staff-supervised program will have at least two qualified first aiders in attendance. The first aid staff will be able to assist with emergency situations that may arise.

Standard First Aid kits will be available on site.

First Aid staff may have limited amounts of the following over the counter medications available to delegates. These will only be given to delegates that have special parental consent, please see attached form to authorize the usage of these medications.

- | | |
|---------------------------------|--------------------------|
| 1. Tylenol - regular strength | 5. Benylin DM |
| 2. Ibuprofen - regular strength | 6. Halls Throat Lozenges |
| 3. Tums | 7. Sudafed |
| 4. Rub A535 | 8. Pepto Bismol |

If your child or ward is prone to headaches, sore throats, or may require any type of medication during the program, please provide the medication in a clearly labeled Dosett, with specific directions from the pharmacist.

If your child or ward brings any medication with them, we will ask that they allow us to safely store it for them. This is for the protection of your child and others.

For all delegates attending a junior or intermediate program, or are under 15 years of age, all medications must be turned in to the program staff at the start of the program. If your child or ward normally carries his/her own medication, you must request in writing that he/she retains responsibility for them.

We also require that any medication, which must be carried around (inhaler, epi-pen, etc.), be carried in a fanny pack for quick and easy access.

Delegates attending programs are responsible for requesting the medication from the First Aider, and administering it to themselves. If you need Staff to ensure that your child or ward receives his/her medication as required, please request this in writing along with the instructions.

Staff will return all medications to the delegates at the end of the program.

If you have any questions or concerns contact **Mark Shand** at 310-0000 then **403-948-8508**.

This form is to be completed and signed by the applicant, or if under 18, by a parent or guardian. Please be sure to read this form carefully to ensure adequate supervision and protection while at the program.



The parent or guardian assumes full responsibility for the participant's health and ensuring that consumption of the following check marked medications will not aggravate any existing condition. **It is assumed that the parent or guardian is aware of the effects that each of the permissible medications have on their child, or will seek competent advice before completing the form. Please do not check off a medication if you are uncertain of the effects it may have on your child or ward.** The parent or guardian will notify the program director if, for any reason, this permission should be withdrawn or changed. **Note: Every care and attention will be given to the health and comfort of the participants. However, neither the program coordinator in charge, or the provincial government shall be held responsible for any accidents that may occur.**

Delegate Information

Last Name:	First Name:	Initial
Mailing Address:		
Town or City:	Postal Code:	
Telephone Number:	Contact Number:	
Age of Delegate:	Approximate Wt:	

Swimming Ability: None Beginner Intermediate Advanced

We may have limited amounts of the following over the counter medications available to us during the program, however we strongly encourage you to send any over the counter medications that you feel your child may need over the course of the program.

Medications: Check (☒) any of the following medications you will authorize your child to receive on request during the stated program.

Tylenol Regular Strength Tums Halls Throat Lozenges Rub A535
 Ibuprofen Benylin DM Sudafed Pepto Bismol
 I do not wish to authorize any of the above mentioned medications.

Delegates attending all programs are responsible for requesting the medication from the First Aider, and administering it to themselves. If you have any special instructions for the administration of the medication please indicate them below, otherwise the delegate will receive the recommended dosage for their weight and age.

Special medication administration instructions:

Having read the above document carefully and completely, I declare the above information is complete and correct to the best of my knowledge. Also, I agree to accept financial responsibility for any medical services in excess of the benefits allowed by any medical insurance coverage the participant may have.

Participant Signature: _____ Date: _____

Parent/Guardian Signature *[Required for all members under 18 years]* _____ Date: _____