City of Las Vegas
Department of Youth Development and Social Initiatives

MEDICATION AND EPINEPHRINE PENS RELEASE FORM

Child's Photo
Must Be Attached

PARTICIPANT'S NAME:_____

Date: _____

The internal procedures on dispensing medication is available for your review at your request and can be found in the parent handbook.

I understand it is my responsibility to give the medication directly to the program staff in an original prescription container with the pharmacist label. Only daily doses are accepted and parents must pick up the empty container each day.

The recommended dosage of any medication will not be exceeded in any case. If after administering medication there is an adverse reaction, I give permission for 911 to be called and to secure any licensed hospital, physician and/or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered.

MEDICINE *(must be in original bottle/container)*	**DOSAGE**	**TIME**
		a.m. p.m.
		a.m. p.m.
		a.m. p.m.
		a.m. p.m.

For How Long/Duration: _____

Doctor's Name: _____

Doctor's Phone Number: _____

Does your child have a medical reason that exempts him/her from wearing a face covering? ☐Yes / ☐No

RELEASE OF LIABILITY, WAIVER OF CLAIMS, AND INDEMNIFICATION

As a condition to being granted access to any facility owned by the city of Las Vegas ("City"), as applicable, and authorization to participate in any event or program, including, without limitation, any class, athletic event, tournament, special event or other activity administered or sponsored by the City (the "Program"), I the undersigned, by signing below, and acting as parent and/or legal guardian of the Program participant ("Participant"), acknowledge the contents of this Form and on my behalf, and on behalf of the Participant and other members of my family, agree that we will advance no claim and we are voluntarily waiving, releasing, indemnifying, and discharging the City and (as applicable) its elected officials, trustees, officers, employees, contractors, volunteers, and agents from any and all injuries, liability, damages, and each and every action (collectively, "Claims") arising directly or indirectly from the distribution or failing to distribute medications to the Participant. For greater certainty and in addition to any other provision herein, I understand that I am assuming the sole risk of any Claims related to the distribution of or the failure to distribute medications to the Participant, and that the indemnity obligations contained herein below cover any such Claims. I understand and agree that this Release and Waiver of Claims includes any Claims based on the actions, omissions, or negligence of the City and (as applicable) its elected officials, trustees, officers, employees, contractors, volunteers, and agents.

In addition to the Release and Waiver set forth above, I the undersigned, and acting as parent and/or legal guardian of the Participant and members of my family, agree to defend at my expense, by legal counsel reasonably satisfactory to City, indemnify and hold the City and (as applicable) its elected officials, trustees, officers, employees, contractors, volunteers, and agents harmless from any and all Claims, demands, suits, judgments, awards or any other form of liability (including court costs and reasonable attorneys' fees) for personal injuries and/or property damage, which is the result of the acts or omissions, negligent or otherwise, in connection with the distribution of or failure to distribute the Participant's medications.

In no event shall the language herein constitute or be construed as a waiver or limitation of the City's rights or defenses with regard to sovereign immunity, governmental immunity, or other official immunities and protections as provided by the Federal and State Constitutions or by applicable law.

PARENT OR LEGAL GUARDIAN

Print Name: _____

Signature:_____

Relationship: _____ Date:_____

CITY OF LAS VEGAS

INDIVIDUAL MEDICATION LOG

Participant Name: _____ **Program Site:** _____

Medication: _____ Dosage: _____ Time: _____

Medication: _____ Dosage: _____ Time: _____

Medication: _____ Dosage: _____ Time: _____

DATE	DAILY COUNT SIGN IN		MEDICATION	DOSAGE	*Staff Dispensing Initials*	DATE DISPENSED	TIME DISPENSED	DAILY SIGN OUT	
	Parent Initial	*Staff Initial*						*Parent Initial*	*Staff Initial*