



Permission and Waiver to Dispense Medication and Medical Information Form

I, _____ give permission to the staff of the Miamisburg Parks & Recreation Department to administer the following:

to: _____

I understand it is my responsibility to give the medication directly to the Parks & Recreation staff in individual dosage containers, original prescription containers, or envelopes clearly labeled with the following information: Participant's name, name of medicine and complete dosage instruction. In all cases the recommended dosage of any medication will not be exceeded. If after administering medication there is an adverse reaction, I give my permission to the City of Miamisburg to secure from 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. I recognize and acknowledge that there are certain risks of physical injury or illness in connection with the administering of medication. I understand that the Parks & Recreation Department does not have medically trained personnel on staff. Neither the City of Miamisburg nor its officers, agents, volunteers, or employees assume any legal responsibility for the administration of medication. In consideration of the City of Miamisburg administering medication, I do hereby fully release or discharge the City of Miamisburg, and its officers, agents, volunteers and employees from any and all liability, claims and expenses from bodily injuries and illnesses, damages and losses I or my minor child may have, arising out of, connected with, incidental to, or in any way associated with the administering of medication or referral of me/my child to medical providers for treatment. I further agree to indemnify, hold harmless and defend the City of Miamisburg, and its officers, agents, volunteers, and employees from any and all liability, claims and expenses resulting from bodily injuries and illnesses, damages and losses sustained by me or my minor child and arising out of, connected with, incidental to or in any way associated with the administering of medication or referral of me/my child to medical providers for treatment.

Signature (Parent/Guardian if under 18)

Date:
