DATE:_____

COUNTY OF LOS ANGELES
DEPARTMENT OF PARKS AND RECREATION

JUNIOR LIFEGUARD PROGRAM

PHYSICIAN'S RELEASE FORM

Junior Lifeguard Name:		
Address:		
City:	**State:**	**Zip:**
Home Phone #		

TO THE PHYSICIAN:

The person you are examining is a participant actively engaged in the Junior Lifeguard Program for the County of Los Angeles Department of Parks and Recreation. As such, this person will be participating in physically demanding activities in a lake setting. Activities will include, but not limited to, swimming, running, boating, calisthenics, and prolonged exposure to sun and heat.

EXAMINATION RESULTS:

The participant named above is:

ABLE ☐ ***NOT ABLE*** ☐ **to participate in the Junior Lifeguard Program.**

Birth Date: **Age:** **Gender: M☐ F☐**

RESTRICTIONS (If any):

RECOMMENDATIONS (If any):

Signature of Examining Physician: **Date:**

OFFICE STAMP: Must be stamped

**** THIS ONLY NEEDS TO BE FILLED OUT IF YOU'RE BRINING MEDICATION TO THE PROGRAM ****

Request Medication/Treatment Given during LA County Jr. Lifeguards Program

(if applicable)

Jr. Lifeguard's Name **Date of Birth**

☐ No known medication allergies. ☐ Allergies : _____

Give daily	**Give as needed**	**Treatment/ Medication** as written on bottle or package	**Dosage in** ml,mg,cc	**Time** actual hour of day	**Route** of delivery	**Reason** medication is given	**Start & End Dates** actual calendar dates	

Special Instructions: _____

If inhaler: (please check one of the following options)

☐ Allow Jr. Lifeguard to carry/administer own inhaler - If needed it will be assisted by EMT Lifeguards

☐ Do Not allow Jr. Lifeguard to carry own inhaler, is to be assisted by and kept with EMT Lifeguards.

If allergy kit (please check one of the following options, 911 will be called if Epi-Pen is administered)

☐ Allow Jr. Lifeguard to carry/administer own Epi-Pen. - If needed it will be assisted by EMT Lifeguards

☐ Do not allow Jr. Lifeguard to carry own Epi-Pen it is to be assisted by and kept with EMT Lifeguards.

I, the undersigned, am the physician for the above named participant and request they receive medication during program hours as ordered above. The parent/guardian is responsible to notify the Jr. Lifeguard Program if the medication, dose, route or time to be given are changed or the medication is discontinued.

Physician's Signature: _____ Date: _____

Physician office number Fax number _____

I, the undersigned, am the parent or guardian of the above, named JG participate, and I hereby request he/she received medication during program hours as ordered by his/her physician. I understand that the County of Los Angeles and any of its personnel are absolved from any civil liability, which might be associated with the medication assistance. I understand that I may retrieve the medication from the camp at any time and the medication will be picked up on my child's last day at camp. I understand that my child's medication will be properly destroyed if not retrieved 7 days beyond my child's last day at camp.

Parent's Signature: _____ Date: _____

Parent's Telephone Number : _____

MEDICATION PROVIDED IN THE ORIGINAL PHARMACY OR MANUFACTURER-LABELED CONTAINER:

Separate bottles need to be provided for camp and home. Only the doses to be given during camp hours should be brought to camp **OFFICE USE ONLY**

Date medication received: # units received:

Director Signature : Group: Exp:

Notes: