PRESCRIPTION AND NON-PRESCRIPTION MEDICATION IN THE CAMP SETTING

DO NOT use this form for inhalers (use Asthma Care Plan) or epi-pen (use Allergy & Anaphylaxis Care Plan).

Written permission for camp supervisor to dispense medication

It is recommended that every possible means be taken to give children medication at home. If it becomes necessary for a student to take **any form of medicine (including over-the-counter medications) the following form must be completed and signed.**

The parent/guardian of _____ ask that the day camp staff give the
(Child's name)
following medication _____ at _____ to my child,
(Name of medication and dosage) (Time(s))

according to the Health Care Provider's signed instructions on the lower part of this form.

- The ENOR program agrees to administer medication prescribed by a licensed health care provider.
- It is the parent/guardian's responsibility to furnish the medication.
- The parent agrees to pick-up expired or unused medication at the end of the camp week.

Prescription medications: must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage and date medicine is to be stopped, and a licensed health care provider's name. Pharmacy name and number is also to be included on the label.

Over the counter medications: must be labeled with child's name. Dosage must match the signed health care provider's authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the camp staff delegated to administer medication.

_____ _____ _____

Parent/Legal Guardian's Name **Parent/Legal Guardian Signature** **Date**

Work phone:_____ **Home/cell phone:**_____

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Health Care Provider Authorization to Administer Medication in Camp

Child's Name: _____ Date of Birth: _____

Name of Medication: _____ Dose: _____

Route: _____Time(s) to be given: _____ Start Date: _____ End Date: _____

May be repeated every_____hours Purpose of Medication: _____

Adverse or Side Effects: _____

Special Instructions: _____

_____ _____

Signature of Health Care Provider w/Prescriptive Authority **Printed Name**

License Number:_____ **Date:**_____

Phone #: _____ **Fax #:** _____