CAMP ADDISON – 2023

PERMISSION FOR MEDICATION ADMINISTRATION

The following information is necessary for any child to possess or use prescribed medication or treatments during any camp program. I hereby request and give permission to designated personnel of the camp to help in the self-administration of medication to my child.

Child's Name (first, middle, last) ____ ☐ Male ☐ Female

Date of Birth ____________________________________ Age _________________________________

Parent/Guardian__________________________________

Address: _______________________ City: ____________________________ State: _______ Zip Code: ____________

Phone (h) ______________________ (w) __________________________ (c) ____________________________

Section I: Physician's Instructions

I am sending medication in the **original container** (with child's name and dosage amount) from our licensed physician/pharmacist. *Please send only the medication that your child will currently need.*

Section I does not need to be completed for certain non-prescription items: fever-reducing medicines that do not contain aspirin; cough or cold medications that do not contain codeine; and topical ointments, creams or lotions.

(Child's Name) ____ is under my care and should receive

(Name of Medicine) ____ (Dosage) ______________, as follows

.

Specific instruction for administration: ____

Possible side effects to watch for: ____

Expiration date (may not exceed six months from date of this request) ____________________________________

Signature of Physician	Date of Signature	Telephone Number

If medication or vitamin is over the counter, physician's instructions and signature are not required. If prescribed medication, please complete the chart below:

RX Number	Pharmacy	
Street Address		**Telephone Number**

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I hereby request and give permission to the administrator or his/her delegate to administer the following medication to my child:

Name of Child	Name of Medication
Dosage Amount	Time(s) of Dosage
Parent/Guardian Signature	Date

I understand and acknowledge that an employee of the camp who is not medically trained may render such assistance. There will not be any designated personnel available for procedures for which specific medical training is necessary. I hereby release and hold harmless the camp and/or its sponsors, volunteers, and employees from any and all liability for damages directly or indirectly resulting from this assistance. I agree to submit a revised signed statement if this information should change at any time.

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FOR OFFICE USE ONLY

Section III: Medication Given by Personnel

(Name of Child) ____was given

(Name of Medicine) ______________________________________ (Dosage) ________________

at the following time(s) on the following dates:

DATE	TIME	NAME OF MEDICATION	DOSE GIVEN	STAFF SIGNATURE