ADMINISTER MEDICATION AT CAMP

Highlighted areas MUST be completed. For completion by parent/guardian.

Name of Camper: _____ Date of Birth: _____/_____/_____
(last) (first) (middle)

Name of School: _____ Grade: _____ School Year: _____

In order for my child to receive medication at camp, I agree to the following:

- All prescription and nonprescription medication will have a physician's signed order fully completed for summer 2015.
- The prescription medication will be in a container labeled by the pharmacist or physician with:
  - ❑ Name of child ❑ Name of medication ❑ Dosage, route and time of administration
  - ❑ Name of physician ❑ Prescription date and expiration date ❑ Conditions for proper storage
- The nonprescription medication will be in the original sealed container with the label intact. Camper's name will be put on the container in a position that does not obscure the label.
- The medication will be brought to camp by an adult.
- The physician will be called if a question arises about my camper's medication.
- The first dose of this medication (except for EpiPen) has been given without problems.

Having ready the above conditions, I request Anne Arundel Community College Health Services personnel administer the medication as prescribed by the physician below. I certify that I have legal authority to consent to medical treatment for the camper named above, including the administration of medication at camp.

Signature of Parent/Guardian: _____ Date: _____

Relationship to Camper: _____

Phone Number: (H) _____ (W) _____ (Cell) _____

FOR COMPLETION BY PHYSICIAN FOR MEDICATION AT CAMP — ONE MEDICATION PER FORM.

Diagnosis: _____

Name of Medication: _____

Dosage: _____ (mg, ml, ml/tsp, # of puffs)

Condition for which the medication is being administered: _____

Route: _____ Time of administration at camp: _____ ❑ Lunchtime

If PRN, for what symptoms _____ How often? _____

Relevant Side Effects: _____ Special Storage Requirements: _____

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed. _____

_____

Camper has allergies to the following medications: _____

For Self Administration of Medication:

❑ Camper **IS** able to self administer inhalant medication, insulin or EpiPen and carry approved medication.
❑ Camper should **NOT** self administer inhalant medication, insulin or EpiPen.

Physician's Signature: _____ Date: _____
Official Stamp

Physician's Name (printed): _____

Address and phone number: _____

FOR KIC STAFF ONLY: ❑ Order reviewed by _____, R.N. Date: _____

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