MEDICATION ADMINISTRATION AUTHORIZATION- CAMP TOCKWOGH

24370 Still Pond Neck Road, Worton MD 21678; 410-348-6000; fax 410-348-6023

THIS FORM must be complete and legible for any and ALL prescription medications and over the counters to be brought to camp. ALL medications must be in original containers and instructions must match prescription label exactly. ALL medications must be **checked in** at Wellness by a parent. If more space is needed, please attach a second sheet and indicate # of pages on the front.

CAMPER NAME_____ DOB_____ WT_____

ALLERGIES_____

TO BE GIVEN ROUTINELY- PRESCRIPTIONS/ OVER THE COUNTER:

Medication dose route frequency/time indication special instructions/known camper- specific side effects

1-_____

2-_____

3-_____

TO BE GIVEN AS NEEDED (PRN)- PRESCRIPTIONS/OVER THE COUNTER:

Medication dose route frequency/time indication special instructions/known camper- specific side effects

1-_____

2-_____

3-_____

SELF-CARRY EMERGENCY MEDS- ONLY EPINEPHRINE OR INHALER OR INSULIN that the camper ROUTINELY self-carries. Parent and physician signature on this document attests that it is prescribed that this camper self-carries this Emergency Rescue Medication; and understands that the medication must be on their person at all times and that **NO MEDS MAY BE LEFT IN THE CABIN**. The signature also attests that they are thoroughly trained regarding storage, symptoms, technique of use and administration, and that **camper agrees to notify wellness staff of any such use. SELF-ADMINISTER-** In rare specific cases, campers may self-administer other medications. Parent and physician signature certify that the camper routinely self-administers and is trained as above. Unless also an emergency rescue self-carry med, all self-administer meds will be kept in wellness and given under the supervision of a designated staff member.

SELF-CARRY EMERGENCY MEDS/SELF-ADMINISTER- Only for Epi-Pen or Inhaler

Medication Name dose route frequency indication special instructions/known camper-specific side effects

1-_____

2-_____

3-_____

***PHYSICIAN AUTHORIZATION** for the above medications for the duration of Camp Tockwogh 2018 season.

★ **Signature, title, and date**_____

Phone and fax_____

PARENTAL CONSENT: I request certified youth camp staff to administer the medication as prescribed. I confirm that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period, an adult must pick up the medication, otherwise it will be discarded. I authorize camp personnel to communicate with the prescriber as allowed by HIPAA. I verify that the child has at some point taken the medication at this dosage prior to attending camp. And that I have read and authorize the consent for self-carry/self-administration if it pertains.

★ **Parent/Guardian Signature** **Date**

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