2021 MEDICATION ADMINISTRATION AUTHORIZATION- CAMP TOCKWOGH

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

- THIS FORM - complete and legible using the same form for additional pages, one med per line
- Signed by physician and guardian for any and all meds listed
- Original container with complete pharmacy/package label which matches this order exactly.
- Unexpired meds- Checked into wellness by the responsible adult.
- Physician authorized "self-carry" or self-administer must be checked in by the parent AND the camper.
- Camper has taken the medication at this dosage prior to attending camp

CAMPER NAME____ DOB__________ WT(#)____________

ALLERGIES____

DIAGNOSES____

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- camp provides routine over the counters for pain, rash, GI, allergy- see parent health form for description

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

1-____

2-____

3-____

SELF-CARRY (SC) EMERGENCY MEDS- ONLY EPINEPHRINE OR INHALER OR INSULIN

Parent and physician signature on this document attests that it is prescribed that this camper self-carries this Emergency Rescue Medication and that they routinely carry it and are thoroughly trained regarding storage, symptoms, and technique of use and administration; That the camper understands that the medication must be on their person at all times (NO MEDS MAY BE LEFT IN THE CABIN) and agrees to notify wellness staff of any use. SELF-ADMINISTER (SA)- 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 is only for Epi-Pen, Inhaler, insulin

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

1-____( )SC; ( )SA

2-____( )SC; ( )SA

3-____( )SC; ( )SA

***PHYSICIAN AUTHORIZATION for the above medications for the duration of Camp Tockwogh 2020 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 authorize camp personnel to communicate with the prescriber as allowed by HIPAA. I understand that an adult must pick up the medication or it will be discarded. I verify that the child has at some point taken the medication at this dosage prior to attending camp. And that I have read, verify, and consent to all of the above.

Parent Email (please print clearly)____

★ Parent/Guardian SIGNATURE Date

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