Medication Administration Permission Form 2019

The parent/ guardian of _____ *(child's Name)*_____ ask that Camp W Day Camp staff give the medication described below to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

Parents/ Guardians MUST supply any of the medication(s) to Camp W that may be administered to your child. The expiration date on the medication bottle MUST NOT EXPIRE BEFORE END OF SUMMER PROGRAM.

Medications: Must come in an original container labeled with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider/s name, Pharmacy name and phone number must also be included on the label.

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

All medications must be picked up by the parent or designated adult at the conclusion of Camp. All medication(s) that are left at the Camp will be discarded according to the most current state regulatory recommendations for safe medical disposal.

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 nurse or Camp staff delegated to administer medication. Further, I acknowledge that medication is administered to my child solely at my request and as an accommodation to me and my child. I understand Camp W does not have the medical personnel on staff at all time to assist in the administration of medication and that medication may be administered by the Divisional administrative assistant or designee. In consideration of the acceptance of the request of the request to perform this service by personnel employed by Camp W, I hereby agree to release Campo W and its personnel from all liability, claims or demands for any damage, loss or injury to my child arising out of the administration of (or failure to administer) the medication.

_____ _____ _____

Print Parent/ Guardian Name Parent/ Guardian Signature Date

_____ _____

Work Phone Home Phone

Health Care Provider Authorization

Childs Name: _____ Birthdate: _____

Medication: _____ Exact Dose: _____ Route: _____

To be given at the following time(s): _____Starting date: _____ Ending Date: _____

Purpose of Medication: _____

Special Instructions including side effects to be reported: _____

_____ License Number: _____

_____ _____ _____

Print name of health care provider Date Phone

FOR CAMP USE ONLY: MEDICATION VERIFICATION CHECK LIST

Delegating RN Signature: _____

Delegated Staff Signature: _____

Completed form must be returned before camper can attend (mail, fax or Email acceptable)

Fax: (631)-367-1509 Email: info@campwadaycamp.com