

INDIAN SPRINGS DAY CAMP
AUTHORIZATION FOR MEDICATION ADMINISTRATION

Physician authorization and parent consent are required for the administration of prescription and over the counter medications in school. **New medication orders are required every summer.**

All medication **MUST** be delivered to the nurse's office by parent/guardian in a secure original pharmacy-labeled container. Please check the expiration dates.

Camper's Full Name: _____ Date of Birth: _____

Allergies: _____

Name of medication (Prescription/OTC): _____

Diagnosis/condition for which medication is prescribed: _____

Route of administration: _____

Dosage: _____ Time(s) of administration: _____

- ☐ Camper is able to self-carry the **following medications ONLY**--diabetes management medications/supplies; glucagon; asthma rescue medication; epinephrine auto injector, during camp or during camp trips.
- ☐ Camper is competent to self-administer diabetes management medication and handle diabetes testing supplies, **emergency medications--which are limited to: asthma rescue inhaler; epinephrine auto injector** during camp or during camp trips.
- ☐ Camper is not permitted to self-carry and/or self-administer any emergency medications.

Physician's Signature

Date

Physician's Printed Name

By signing below, parent requests the administration of the above-named medication as prescribed by the authorizing physician AND acknowledges their consent to permit their camper to self-carry and/or self-administer diabetic management medications/supplies and/or emergency medications, as determined by the physician's authorization stated above.

Camper must demonstrate administration competency to camp nurse.

Parent/Guardian Signature

Date

Parent/Guardian Printed Name

IN OFFICE USE ONLY:

Date/time of med. drop-off: _____

Name of person dropping off: _____

Med. Name: _____

Amount of medication: _____

Expiration Date: _____

Signature of drop off person

Camp Staff Signature/Printed Name