

MEDICATION & OVER-THE-COUNTER AUTHORIZATION

Camping Regulations require that this form be completed and signed by a parent/guardian **AND** a physician in order that the camp may store and administer medications during camp operating hours.

All medications must be in a pharmacy-labeled or original container with the name of the child below as the prescribed, name of the drug, strength, dosage, frequency, authorized prescriber and the date of the original prescription.

You may NOT send medications with your child to camp. Medications MUST be hand-delivered by the authorizing parent/guardian. Certain medications such as inhalers and epi-pens may be allowed to be carried by the camper at the Camp Director's discretion and if indicated by parent/guardian.

All medications are kept in locked storage in the camp office and can only be accessed by designated personnel.

Camper/Staff Name		Age:
Date of Birth	Guardian Name & Relationship to Camper	
Address		
Cell Phone	Alternate Phone	

DRUG INFORMATION:

Drug Name _____

Dose _____ Method _____

Time _____ Administered between these dates _____

Relevant side effects to be observed, if any _____

If side effects, plan for management _____

Is this a controlled drug? _____ Allergies or interactions with other food/drugs _____

If "When Needed" describe indications _____

Print Name of Camper's Physician: _____ Phone: _____

 City _____ State _____ Zip _____

A physician's signature is required for ALL medications – including any OTC medications/pills/creams.

Physician Signature: _____ **Date:** _____

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above medication or over-the-counter drug, approved and ordered by an authorized doctor for my child, be administered by the camp health provider during day camp operation hours specified above. I understand that I must supply the camp with the appropriately prescribed medication in the original container dispensed and properly labeled by an authorized prescriber. Over the counter medications will be in their original packaging and have my child's full name clearly labeled. I understand that if not picked up, this medication will be destroyed after one (1) business week following the termination of the order or end of participation in Rye Y Camp programs.

I give my child permission to self-administer and carry his/her prescribed inhaler or epi-pens as directed by the child's physician. Yes No

Parent/Guardian Signature: _____ **Date:** _____