



# Request for Administration for Medication

## (ONE FORM PER MEDICATION)

No medications are allowed at Calais Recreation Camp unless this form is filled out completely.

### Requirements for Medications:

All medications must be in the original container with the medication name visible. The container must have the child's first and last name on it. Medications should be placed in a Ziploc bag labeled with the child's first and last name.

**Medication Drop-off:** All medications must be given to the Camp Director or authorized staff at the start of each day.

**Exception: If the prescription medication is an emergency medical device and you prefer your child to carry it, complete Section 3**

### Section 1: Must be completed by parent/guardian

Camper's Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Exact Dosage: \_\_\_\_\_

Frequency: \_\_\_\_\_ Time(s) of Administration: \_\_\_\_\_

Special Instructions (if any): \_\_\_\_\_

I, the undersigned parent/guardian, authorize the administration of the above medication to my child during their participation in the day camp. I understand that it is my responsibility to provide the medication in its original packaging, with the medication name visible, it must have the child's first and last name on the container, and it must be in a Ziploc bag with the child's first and last name on it, and with clear dosage instructions. I also understand that the camp staff will make reasonable efforts to ensure the safe administration of the medication but cannot be held responsible for unforeseen reactions or events.

**X** Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### Section 2: Must **ALWAYS** be completed by a licensed physician, licensed dentist, or nurse practitioner.

Name of Child Receiving Care: \_\_\_\_\_ Name of Medication: \_\_\_\_\_

Dosage Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_

Specific Instructions for Administration: \_\_\_\_\_

Possible side effects to watch for: \_\_\_\_\_

I, the undersigned healthcare provider, authorize the administration of the above medication to the camper named above. I confirm that the medication and dosage specified are appropriate for the camper's condition.

**X** Signature of Healthcare Provider : \_\_\_\_\_ Date: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Section 3: Must be completed by parent/guardian

#### Section 3: WAIVER TO CARRY EMERGENCY MEDICAL DEVICE

Due to the possible necessity for immediate medication distribution imposed by my child's life-threatening condition, I \_\_\_\_\_, request that (child name) \_\_\_\_\_ be allowed to keep the appropriate prescribed device on his/her person while participating in all day camp activities. My child has the knowledge and skills to safely self-administer this medication at camp when needed.

\* The prescribed device is a \_\_\_\_\_ EpiPen \_\_\_\_\_ Asthma Inhaler \_\_\_\_\_ Other: \_\_\_\_\_

**X** Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_