Camp Cadet Administration of Medication
(To be completed by physician)

Camper's Name_____ Date of Birth_____
If it is essential that this student receive prescription medication during camp, complete the following information. <u>A separate form is required if medications exceed the number of spaces on this form.</u> Medications must be brought to the camp in their original bottle/packaging by parent or guardian. Doctor medication orders on this form must match the orders on the medicine bottle received at camp. If NO prescription medication is needed, please strike through form and return.

Physician's Order:

Medication_____ Dose: _____ Route: _____

Time schedule for administration: _____

Diagnosis for medication administration: _____

If medication is PRN, describe indications: _____

May PRN medication be repeated? _____ If so, how soon? _____

********Only for Inhalers and EpiPens********
Student may SELF-MEDICATE this medication at camp: Yes_____ No_____
***I certify that this student is qualified and able to self-administer this medication (SELF-MEDICATION is permitted for non-scheduled medication only)**

Physician's Name (please print): _____

Physician's Signature: _____

Phone: _____ Date: _____

Parent's Authorization:

_____**I/We authorize selected camp staff to administer this prescribed medication.**
By doing so, I relieve the camp and its employees of responsibility for the benefits or consequences of the prescribed medications.

_____**I/We authorize this student to <u>self-medicate</u> this prescribed medication**.
By doing so, I acknowledge that the camp is not responsible for ensuring that the medication is taken and I relieve the camp and its employees of responsibility for the benefits or consequences of the prescribed medication.

Parent/Guardian Signature: _____ Date _____

-OVER if additional space needed-

Camper's Name_____ Date of Birth_____

Physician's Medication Order:

Medication_____ Dose: _____ Route_____

Time schedule for administration: _____

Diagnosis for medication administration: _____

If medication is PRN, describe indications: _____

May PRN medication be repeated? _____ If so, how soon? _____

********Only for Inhalers and EpiPens********
Student may SELF-MEDICATE this medication at camp: Yes___ No____
***I certify that this student is qualified and able to self-administer this medication (SELF-MEDICATION is permitted for non-scheduled medication only)**

Physician's Medication Order:

Medication_____ Dose: _____ Route_____

Time schedule for administration: _____

Diagnosis for medication administration: _____

If medication is PRN, describe indications: _____

May PRN medication be repeated? _____ If so, how soon? _____

********Only for Inhalers and EpiPens********
Student may SELF-MEDICATE this medication at camp: Yes___ No____
***I certify that this student is qualified and able to self-administer this medication (SELF-MEDICATION is permitted for non-scheduled medication only)**

Physician's Medication Order:

Medication_____ Dose: _____ Route_____

Time schedule for administration: _____

Diagnosis for medication administration: _____

If medication is PRN, describe indications: _____

May PRN medication be repeated? _____ If so, how soon? _____

********Only for Inhalers and EpiPens********
Student may SELF-MEDICATE this medication at camp: Yes___ No____
***I certify that this student is qualified and able to self-administer this medication (SELF-MEDICATION is permitted for non-scheduled medication only)**

Physician's Name (please print): _____

Physician's Signature: _____