



Health/Medication Authorization Form

Complete this form for any individual with medical/behavioral concerns, medication (prescription/non-prescription), and/or emergency medical devices. This form must be completed fully. A new health/medication form must be completed at the beginning of each camp season, for each medication, and each time there is a change in dosage or distribution of medicine. Prescription medication must be in a container labeled by the pharmacist or prescriber. Non-prescription medication must be in the original container with the instructions for use. Non-prescription medication includes over-the-counter, vitamins, homeopathic, and herbal medicines. An adult must bring the medication to camp and give the medication to the adult camp operator/camp staff on site. Program staff will verify in writing the amount of medications they have accepted for an individual (up to 2 weeks).

I. GENERAL INFORMATION

Participant Name: Pass Type

Address:

II. MEDICATION – PRESCRIBER’S AUTHORIZATION

A separate form must be completed for each medication the individual may need during camp hours. Individuals MUST be able to name and recognize, know the proper dosage and how to administer their medication. The first dose of any new medication must be taken 24 hours prior to attending an SFLV program. Individuals enrolled in Summer Camp may self-administer a prescription, including emergency medical devices and over the counter medications during day camp hours.

Name of Medication (includes emergency medical devices):

Reason for medication: Emergency Medication: YES (see section IV) NO

Medication Dose/Frequency: If PRN, what symptoms?

Possible side effects of medication:

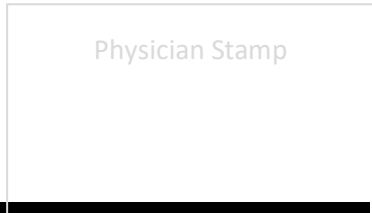
MEDICATION TAKEN AT HOME: Parent Signature: Date:

MEDICATION TAKEN DURING PROGRAM HOURS

Physician Name & Title (printed):

Physician address:

Prescriber’s Signature: Date:



III. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator/staff to supervise the camper in self-administration if authorized as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the distribution of medication at the facility. I understand that at the end of the authorized period, an adult must pick up the medication; otherwise it will be discarded within ONE WEEK of the camper leaving camp. I authorize camp personnel to communicate with the prescriber as allowed by HIPAA. I agree to release the M-NCPPC and its agents from any and all liability arising as a result of this waiver.

Printed Name (Parent/Guardian) Signature (Parent/Guardian) Date

IV. AUTHORIZATION FOR SELF-CARRY

This section should only be completed if this medication is approved for self-administration. Self-carry is only permitted for emergency medical devices such as inhalers or epinephrine. Both the prescriber and the parent/guardian must consent to self-administration by signing below, however camp operators are not required to permit self-administration or self-carry.

I consent that the child named above is able to self-administer the medication listed. I authorize self-administration of the above listed medication for the child named above under the supervision of an authorized youth camp operator/staff member. If indicated below, the child named above may self-carry emergency medication. I agree to release the M-NCPPC and its agents from any and all liability arising as a result of this waiver.

Prescriber’s Signature: Self-Carry Do NOT Self-Carry N/A (non-emergency)

Parent/Guardian’s Signature: Self-Carry Do NOT Self-Carry N/A (non-emergency)

V. ALLERGY/OTHER INFORMATION

Does the individual have any allergies staff should be aware of?

- None Food Medication Environmental (pollen, poison ivy, etc.)

Describe Allergy: Reaction Level: Mild Moderate Severe

Required Treatment:

Are there any health concerns staff should be aware of?

- No Yes Please Explain:

Are there any physical, psychiatric, behavioral, emotional, or developmental concerns staff should be aware of?

- No Yes Please Explain:

Date of Last Seizure (if applicable):