



Prescription Medication

Any medication that requires a prescription from a physician that the camper will need to take while at camp.

Please complete a form for each prescription medication your camper will take during camp.

Camper Name: _____ Date of Birth: _____

Camper Address: _____

To Be Completed by a Doctor/Healthcare Provider:	
Name of Medication: _____	Dose: _____
Time(s) to be given: _____	
Form of Medication: Tablet: <input type="checkbox"/> Liquid: <input type="checkbox"/> Inhaler: <input type="checkbox"/> Nebulizer: <input type="checkbox"/> Other: _____	
Start Date: _____	Stop Date: _____
Special Instructions: _____	
Is there a need for a specialized diet? (if yes specify): _____	
Potential adverse reactions to be reported to parent or doctor: _____	
Physician/Provider Name (print): _____ Date: _____	
Physician/Provider Signature: _____	
Phone _____	Fax () _____

Parent/Guardian: I give permission for my child to receive this medication at camp according to camp policy and as instructed by my healthcare provider.

I agree and am responsible to:

- Deliver this medicine to camp in its original container and labeled by a pharmacist or healthcare provider.
- Tell the camp as soon as possible if there is a change in the use of this medicine.
- Tell the camp if my child gets a new healthcare provider.
- Complete a new medicine form for this medicine if the dose changes.
- Have my healthcare provider complete a new medicine form if the medicine or dose changes.

I agree for my child's healthcare provider to talk with the camp personnel about this medication. No other part of my child's health will be discussed.

Parent/Guardian Signature: _____

Parent/Guardian Phone: () _____ Emergency Alternate Phone: () _____