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: ☐ Liquid: ☐ Inhaler: ☐ Nebulizer: ☐ 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: ( ) _____

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