MEDICATION ADMINISTRATION AUTHORIZATION FORM

Camp Sonshine
16819 New Hampshire Ave
Silver Spring, MD 20905
Tel: 301-989-2267
Fax: 301-989-7116
info@campsonshine.org

I. CAMP OPERATOR

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self administer medication. A new medication administration form must be completed at the beginning of each camp season, for each medication, and each time there is a change in dosage or time of administration of a medication.

- **Prescription medication must be in a container labeled by the pharmacist or prescriber.**
- **Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.**
- **An adult must bring the medication to the camp and give the medication to an adult staff member.**

II. CAMP INFORMATION

YOUTH CAMP NAME **Camp Sonshine**

PHYSICAL ADDRESS **16819 New Hampshire Ave**

CITY **Silver Spring** STATE **MD** ZIPCODE **20905**

III. PRESCRIBER'S AUTHORIZATION

CHILD'S NAME		DATE OF BIRTH
CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:		EMERGENCY MEDICATION [ ] YES [ ] NO
MEDICATION NAME	DOSE	ROUTE
TIME/FREQUENCY OF ADMINISTRATION	IF PRN, FREQUENCY	
IF PRN, FOR WHAT SYMPTOMS		
KNOWN SIDE EFFECTS SPECIFIC TO CHILD		
MEDICATION SHALL BE ADMINISTERED *(NOT TO EXCEED 1 YEAR)*	FROM	TO

PRESCRIBER'S NAME/TITLE			This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIPCODE	

PRESCRIBER'S SIGNATURE ***(Parent cannot sign here)*** *(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)*	DATE

IV. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator/staff to administer the medication or 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 administration 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. I authorize camp personnel to communicate with the prescriber as allowed by HIPAA.

PARENT/GUARDIAN SIGNATURE		DATE
HOME PHONE #	CELL PHONE #	WORK PHONE #

V. AUTHORIZATION FOR SELF ADMINISTRATION AND 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. The child named above may self carry emergency medication if indicated below.

PRESCRIBER'S SIGNATURE	SELF CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] Not emergency medication	DATE
PARENT/GUARDIAN'S SIGNATURE	SELF CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] Not emergency medication	DATE

Counselor: _____ **Head Counselor:** _____

WEEKS ATTENDING: 1 2 3 4 5 6 7 8 9 10

MEDICATION WAIVERS

In order to help camp run smoothly, it is extremely important to drop off medication by the Thursday before the week your child is attending.

STAFF CARRYING MEDICATION WAIVER AND RELEASE FORM

(to be signed if parent elects to have a staff member carry emergency medication for the child)

By signing this waiver, I understand and agree to the following:

1. Requesting the counselor to carry my child's medication is an exception to the normal procedures in effect at Camp Sonshine.
2. As stated in the Parent Guide (p 10-11), Camp Sonshine prefers campers carrying their own emergency medication on them in the following way:
   Pre-K through 4th grade should carry all emergency medication in a hip pack, which is worn at all times.
   5th grade through 10th grade should carry emergency medication in a hip pack, which is worn at all times.
3. The above mentioned guidelines have been set in place by Camp Sonshine to ensure campers have their medication readily available throughout the camp day.
4. I understand that my request does not guarantee that my child's counselor and / or any other party representing Camp Sonshine will have my child's medication readily available in case of an emergency.
5. I hereby release the counselor and all other parties representing Camp Sonshine of any liability as a direct result of not having the medication readily available when needed.

_____ _____

Parent's Signature Parent Name (Please Print)

_____ _____ _____

Camper's Name (Please Print) Camper's Grade Date

LATE MEDICATION WAIVER

(to be signed if medication is brought in after deadline)

By signing this waiver I understand that I have brought in my child's medication after the date requested on page 10 of the Parent Guide. I understand that the Camp Sonshine staff will do their best to ensure that the medication becomes readily available to my child but also release the Camp Sonshine staff from any responsibility due to the medication not being at camp by the medication not being at camp by the requested date of the Thursday prior to each week enrolled.

_____ _____

Parent's Signature Parent Name (Please Print)

_____ _____ _____

Camper's Name (Please Print) Camper's Grade Date

OFFICE USE ONLY

DATE RECEIVED _____ TIME RECEIVED _____ RECEVEIVED BY _____

LOCATION: Camper Nurse's Station Staff/Waiver