CAMPER’S Name ___________________________________________ Camper’s Age __________

Camp/Program(s) & Dates (e.g. Explorer, Blue, Cal Adventures, Skateboard, S2) __________________________

FORM MUST BE COMPLETED BEFORE ANY MEDICATION IS BROUGHT TO CAMP
This form must be completed and signed for prescribed and non-prescribed medications by the parent/guardian, and for prescribed medications, by a physician, before any medication can be administered at camp. All medications, whether prescribed or non-prescribed, are kept in the camp office. If you would like your child to carry either an asthma inhaler or other emergency medication (i.e. Epipen or Glucagon), form must be completed and signed by the camper’s legal guardian. ***The parent or adult representative must bring all medications to camp in their original container ***

****DO NOT SEND MEDICATIONS WITH YOUR CHILD.****

PART 1: PARENT/GUARDIAN: Both prescribed and non-prescribed medications will be administered by authorized camp personnel in the manner and dosage given. By signing below I hereby request that authorized personnel assist this camper in taking the medication in the manner and dosage given. I understand all medications must be in their original container.

PERMISSION TO CARRY ASTHMA INHALERS/EPIPENS
The above-named camper has been instructed in the proper use of their asthma inhaler/emergency medication. The child’s well-being is in jeopardy unless this medication is carried on his/her person. Therefore, I request that he/she be permitted to carry the asthma inhaler/emergency medication at camp. He/she understands the purpose, appropriate method, and frequency of use of asthma inhaler/emergency medication.

PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS (OTC)
I (Parent/Guardian) hereby give permission for Cal Youth & Outdoor Programs, to administer to my child, the following over-the-counter medications (or their Generic Equivalents) if the camp medical personnel deems it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise. It is the intent of program staff to encourage and use, non-drug therapies before recommending or administering pharmaceuticals.

Permission is granted to administer the following OTC medications: ☐ No ☐ Yes If yes, please check all that apply.
☐ Tylenol® (Headache) ☐ Pepto Bismol® or other Ant-Acid (Upset Stomach) ☐ Benadryl (Allergic Reactions)

Name of Medication _____________________________ Form _____________________________ Dose _____________________________

Schedule of Doses (When) _____________________________ Date to Stop Medication _____________________________

Restrictions, Cautions, Side Effects _____________________________

X Parent/Guardian Signature _____________________________ Printed Name/Relationship _____________________________

______ Main contact phone _____________________________ _______ Alternate contact phone _____________________________

PART 2: PHYSICIAN: Confirm above medication information (Signature not needed if non-prescription medication)

X Physician Signature _____________________________ Printed Name _____________________________ Date _____________________________

Physician Phone # (_____ ) _____________________________ Address _____________________________

PART 3: CAMP DIRECTOR (to be completed by Camp Director or designated camp medical staff)

Person(s) designated by camp director to assist camper in taking medication above _____________________________

X Signature of Camp Director or designated camp medical staff _____________________________ Date _____________________________

This information to be used by Camp Director and authorized personnel only.

J:\CRS\MEDICAL\Medication form 1_7_08.doc 1/7/2008