2024 Camp Tockwogh Medication Administration Form

24370 Still Pond Neck Road Worton, MD 21678 • Phone: 410-348-6000 • Fax: 410-348-6023

CAMPER NAME: _____ **DOB:** _____ **WEIGHT:** _____

ALLERGIES: _____

DIAGNOSES: _____

INSTRUCTIONS TO COMPLETE THIS FORM

- This form must be complete & legible. Please list one medicine per line, and use this same form for additional pages
- This form must be signed by the physician and parent/guardian for any/all medications and vitamins listed on this form
- Medicine must be in the original container with complete pharmacy/package label which matches this order exactly (this includes topical solutions, birth control, inhalers, EpiPens)
- Medicine must be unexpired and checked into our wellness staff by a responsible adult
- Physician authorized "self-carry" or "self-administer" must be checked in by the parent AND the camper
- Camper must have taken the medication at this dosage prior to attending camp

IF THE CAMPER IS BRINGING ANY MEDICATION (Prescription or Over-The-Counter) FILL IN THE BOX BELOW

TO BE GIVEN ROUTINELY: *List any prescription & over-the-counter medication*

MEDICATION dose strength quantity route frequency time indication special instructions/known camper specific side effects

1. _____
2. _____
3. _____

TO BE GIVEN AS NEEDED (PRN): *List any prescription & over-the-counter medication. Camp provides routine over-the-counter for pain, rash, GI, allergy*

MEDICATION dose strength quantity route frequency time indication special instructions/known camper specific side effects

1. _____
2. _____
3. _____

PARENT/GUARDIAN CONSENT & AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized 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 authorized individual must pick up the medication; otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

EMAIL: _____ PHONE: _____ SECONDARY PHONE: _____

PHYSICIAN AUTHORIZATION

Physician authorization for the above medications for the duration of the 2024 camp season

PHYSICIAN SIGNATURE: _____ TITLE: _____ DATE: _____

IF THE CAMPER IS BRINGING SELF-CARRY OR SELF-ADMINISTER MEDICATION

SELF-CARRY (SC) EMERGENCY MEDICATIONS: *This includes epinephrine, inhaler, or insulin only*

Parent & physician signature on this documents attests that it is prescribed that this camper self-carries this Emergency Rescue Medication and that they routinely carry it and are thoroughly trained regarding storage, symptoms, and technique of use administration; That the camper understands that the medication must be on their person at all time (NO MEDICATIONS MAY BE LEFT IN THE CABIN) and agrees to notify wellness staff of any use

SELF-ADMINISTER (SA)

In the rare specific cases, campers may self-administer other medications. Parent and physician signature certify that the camper routinely self-administers and is trained as above. Unless also an emergency rescue self-carry medication, all self-administers medications will be kept in wellness and given under the supervision of a designated staff member

MEDICATION dose strength quantity route frequency time indication special instructions/known camper specific side effects

1. _____
2. _____

I authorize self-administration of the above listed medication for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer.

AUTHORIZED PRESCRIBER: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____