BEULAH BEACH CAMP & RETREAT CENTER

MEDICATION AUTHORIZATION FORM

All campers under the age of 18 years old who bring prescription or over-the-counter medications to be taken at camp require a Medication Authorization Form on file. A Medication Authorization Form must be completed and signed by the parent/guardian for over-the-counter medications or parent/guardian and Doctor or Nurse Practitioner for prescription medication. Campers may not keep and take medications on their own (exception is made for asthma inhalers and epi pens as indicated below in the health care provider section). All medications are to be given to the Camp Nurse at the time of registration. ***All over-the-counter medications must be received in the original package containing directions for dosage. All prescription medications must be received in the original pharmacy bottle labeled with the camper's name and a current expiration date.*** *NO MEDICATION WILL BE RECEIVED OR ADMINISTERED IF BROUGHT IN A PILL ORGANIZER, BAGGIE, OR OTHER CONTAINER. This authorization is valid for the camp year 2020. Any additions or changes in medication, dosage or time of administration require a new form completed and signed by the parent/guardian and health care provider.*

PARENT/GUARDIAN SECTION:

I, the undersigned as legal parent/guardian of _____, date of birth_____, attending _____ (camp), dates _____, request the Camp Nurse (or designee under the direction of the Camp Nurse) administer the following listed medication(s) to my child . I authorize, as needed, the sharing of information related to my child's health between the Camp Nurse (or designee) and the health care provider listed below.

_____ _____

Date_____Printed name and signature of Parent/Guardian _____.

_____ _____ _____

Home Address Contact phone # 1 Contact phone # 2

I hereby instruct the Camp Nurse (or designee) to assist the above camper in taking:

Medication	Dosage	Route	Time	Diagnosis/condition:

HEALTH CARE PROVIDER SECTION:

In my professional opinion, this camper may carry and self-administer an asthma inhaler and/or epi pen. YES NO N/A

_____ _____

Printed name of health care provider Address & Telephone #

_____ _____

Signature of health care provider Date