Medication Administration Instructions

Student Name:_____ Date of Birth:_____

Allergies:

_____
_____
_____

Medical History:

_____
_____
_____
_____
_____
_____

Emergency Contact Name and Number:

_____

Medication Dose Frequency/Time/Route

_____
_____
_____
_____

Sign In Signature for Medication:
This signature allows the registered nurse to administer prescribed medications and pre-approved over the counter medications to my child during the dates of July 11th -15th. I acknowledge it is my child's responsibility to be present at medication administration times and to take their medications as prescribed.
Signature: _____

Sign Out Signature for Medication:
This signature acknowledges medications were returned upon the students return from camp without questions or concerns.
Signature: _____

*Controlled substances must be counted when signing in and signing out medications.

Sign in parent:_____/Witness:_____

Sign out parent:_____/Witness:_____

By signing this section, I am giving my child permission to carry their EpiPen or rescue inhaler. I understand the risks and the responsibility involved in allowing my student to have their rescue medications.

My child will be carrying their own EpiPen/rescue inhaler
Signature: _____
OR
I want my child's adult leader to carry EpiPen/rescue inhaler
Signature: _____

Parent signature: _____

Adult Leader Signature: _____
(If rescue medications are prescribed and parent authorizes)