MEDICATION CONSENT FORM FOR Y-CAMPS

CHILD INFORMATION

1. Childøs first and last name:	2. Date of birth:	3. Childøs known allergies

MEDICATION INFORMATION

4. Name of Medication (including strength):	5. Amount/Dosage to be given:	6. Route of administration:

7A. Frequency to be administered: ____________________

OR

7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) ____________________

8A. Possible side effects: ☐ See package insert for complete list of possible side effects (parent must supply)

AND/OR

8B. Additional side effects: ____________________

9. What action should the camp take if side effects are noted:

☐ Contact parent ☐ Contact prescriber at phone number provided below

☐ Other (describe): ____________________

10A. Special instructions: ☐ see package insert for complete list of special instructions (parent must supply)

AND/OR

10B. Additional special instructions: (include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the childøs age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.)____________________

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11. Reason the child is taking medication (unless confidential by law): ____________________

PRESCRIBER INFORMATION

14. Date prescriber authorized:	15. Prescriberøs telephone number:

16. Prescriberøs name (please print):

17. Licensed authorizes perscriberøs signature:

DOUBLE SIDED FORM

PARENT INFORMATION

18. Date parent or legal guardian authorized:	19. Parent/Legal Guardianøs telephone number:
20. I, parent/legal guardian, authorize the camp to witness the self-administration of the medication as specified in the medication information section to ____(childøs name)	
21. Parent or legal guardianøs name (please print):	
22. Parent or legal guardianøs signature:	

CAMP INFORMATION

23. Camp Name:	24. Camp Phone Number
25. I have verified that #1-#22 are complete. My signature indicates that all information needed to witness the self-administration of this medication has been given to the camp: ______________________________	
26. Camp Director or Health Directorøs name (please print):	27. Date received from parent:
28. Camp Director of Health Directorøs signature:	
29. Date parent notified to pick up medication: ______________	Staff Signature: ______________________
Date picked up by parent: ________________________	Date Discarded: ______________________

DOUBLE SIDED FORM