Medication Administration Authorization Form

This form must be completed fully in order for Camp Bountiful staff to administer the required medication. A separate medication administration form must be completed for each medication.

*** Prescription medication must be in a container labeled by the pharmacist or prescriber.**

***Non-Prescription medication including vitamins, homeopathic and herbal medication must be in original container with label intact.**

***An adult must bring the medication to the camp.**

***The camp medical staff will call prescriber as allowed by HIPAA,if a question about the camper and/or the camper's medication.**

Prescriber's Authorization

Name of Camper: ____

Name of Medication:____

Condition for which medication is being administered:___________________________

Dose:_________________________________ Route_______________________________

Time/Frequency of administration:____

if PRN,frequency:____

if PRN, for which symptoms:____

Relevant Side Effects: none expected _________Specify___________________________

This medication shall be administered during the summer of 2015 while this camper is attending Camp Bountiful unless more restrictive dates are specified here: _________

Prescriber's Name/Title:____

Telephone:_________________________Fax_____________________________________

Address:____

Self-Carry/Self-Administration of Emergency Medication Authorization/Approval

Self carry/self administration of emergency medication such as inhalers ,insulin and Epipens must be authorized by the prescriber and may be approved by the camp medical staff.

Prescriber's authorization for self carry/self administration of emergency medication

Signature____Date____________

Parent/Guardian Authorization

I/We request designated camp personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the camper named above, including administration of medication at camp. I/we understand that at the end of each camp session, an adult must pick up the medication, otherwise it will be discarded. I/we authorize the camp medical staff and camp directors to communicate with health care provider as allowed by HIPAA.

Parent/Guardian Signature: _________________________________Date:_____________