

Medication Administration Authorization Form - 2020

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 2019 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: _____