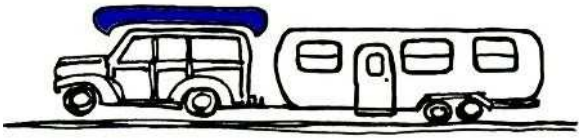
AMERICAN WANDERER



American Wanderer, LLC RVCamp for Kids

Prescription Medication Permission Form

(Authorization to Administer/Dispense Prescription Medications by Camp Personnel)
Connecticut State Law requires an authorized prescriber's (M.D., DDM, P.A., APRN) written order & parent/guardian's authorization for a camp director to dispense/administer medications.
 Prescription Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber or dentist's name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name (See separate form).
(This Section MUST be SIGNED by a Physician!)
AUTHORIZED PRESCRIBER: PHYSICIAN'S OR DENTIST'S ORDER: Date ____/____/_____
Name of Child _____Date of Birth____/____/____
Street Address_____ City/Town _____State____
Condition for which drug is being administered during camp hours _____
DRUG: Name of Drug, Dose and Method of Administration _____
Times of Administration: ____, _____, ____ Medication shall be administered from ____/____/____-
____/____/____
Relevant side effects to be observed, if any
_____
_____
If there are side effects, plan for management
_____
_____
_____
Is this a controlled drug?
_____
Allergies, reaction to, or negative interaction with food or drugs? If YES, list
_____
_____
The authorized Physician's or Dentist's Name_____ Phone # (_____) _____
(Print Name Clearly)
Street Address_____City/Town_____State____

Authorized Prescriber: Physician's or Dentist's Signature_____

Authorization by Parent/Guardian for the administration of the above medication:
Date: ____/____/____
(Parent's Signature Required!)
I hereby request that the above medication, ordered by the authorized prescriber: (M.D., P.A., APRN) /dentist for my child_____, be dispensed by a camp director.
I understand that I must supply the Camp with the prescribed medication in the original container dispensed and properly labeled by an authorized prescriber dentist or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name (use separate Nonprescription Medication Permission form). I understand that this medication will be destroyed if it is not picked up within one (1) week following camp.
Name of Parent or Guardian _____
(Print Name Clearly)

Signature _____

Relationship to child _____
Street Address_____
City/Town_____ State_____ Zip Code_____
Phone (_____) _____