Medication/Physician's Form

Student Name: _____ **DOB:** _____ **Date:** _____

To be completed by parent:

I understand that:

Non-medical personnel conduct the medication administration.

It is my responsibility to have an adult transport the medication to camp.

If medication is not available at the camp, 911 will be called for emergencies.

If my child participates in Camp Musart activities/sports, I will assume responsibility for contacting the advisor/coach of my child's medical condition. I will provide extra emergency medications that may be needed during the activity. I may contact the camp administrator if assistance is needed in instructing the advisor in a medical procedure or if a copy of the information needs to be shared with them.

I request that:

My child be administered the medication as indicated in the physician's order.

If an emergency injection is ordered, I give permission for the camp administrator to instruct designated staff in the administration technique.

I authorize:

The release and exchange of medical information between my child's physician and camp administrator that is necessary in carrying out services for my child.

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician.

I hereby release Camp Musart and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

Parent/Guardian Signature: _____ **Date:** _____ **Phone:** _____ **Phone:** _____

Student Self-Carry and Self-Administration of Emergency Medication

To be completed by Physician:

The student must have the medication(s) listed on the reverse side during the camp day. **Adult supervision is not needed.** The student has been instructed in the treatment plan, self-administration for the listed medication(s) and has demonstrated the skill level necessary to self-administer medications for:

☐ Asthma ☐ Allergy ☐ Insulin Other: _____

For Epinephrine Auto Injector Only:

In the event the student is experiencing respiratory difficulty and is unable to administer the Epinephrine Auto Injector, the camp administrator will train designated school staff to administer the Epinephrine Auto Injector and call 911.

Printed Physician's Name: _____

Physician's Signature: _____ **Date:** _____

To be completed by student at camp:

- ☐ I have demonstrated the use of my medication to the camp staff listed.
- ☐ I plan to keep my medication and equipment with me at camp.
- ☐ I will use only as prescribed by my doctor.
- ☐ I will not allow any other person to use my medication.
- ☐ I will notify a camp staff member if I am having more difficulty than usual with my health condition.

Student Signature: _____ **Date:** _____

To be completed by Parent:

I request and give permission for my child to carry and give the medication listed on the reverse side during the camp day. **Adult supervision is not needed.**

I understand that:

I shall provide the camp back-up medication (in addition to what student will carry).

My child will be required to demonstrate the skill level necessary to use the self-administered medication.

My child will be subject to disciplinary action if medication is used in any other manner than prescribed.

For Epinephrine Auto Injector Only:

In the event my child is experiencing respiratory difficulty and is unable to administer the Epinephrine Auto Injector ordered by the physician, a trained school staff member may administer the Epinephrine Auto Injector and call 911. I have observed my child demonstrate the necessary skill level to implement the care plan prescribed by his/her health care provider.

Parent Signature: _____ **Date:** _____

To be completed by camp administrator:

I have observed the student indicated above verbalize and demonstrate the skill level necessary to use the medication prescribed by the above physician.

☐ Epinephrine Auto Injector ☐ Inhaler

Camp Administrator Signature: _____ **Date:** _____

Medication/Physician's Form

Student Name: _____ **DOB:** _____ **Date:** _____

	Diagnosis	Name of Medication (**Right** Medication)	Dosage (**Right** Amount)	How to give (**Right** Route)	Time(s) to Give (**Right** Time)	Medication Log Date/Staff Signature				
						1	2	3	4	5
Daily Medication(s)	ADHD Cystic Fibrosis Seizures Diabetes Other:									
Emergency Medication(s)	Allergy Allergen: _____	Diphenhydramine (Benadryl)	12.5 mg 25 mg Other: _____	By Mouth	Upon Exposure Mild Reaction					
		Epinephrine Auto Injector	0.15 mg 0.3 mg	Intramuscular (IM)	Upon Exposure Severe Reaction If provided, repeat dose after ____ min for continued symptoms.					
	Diabetes	Glucagon	0.5 mg 1.0 mg	Subcutaneous (SQ)	If student becomes unconscious					
Asthma	Exercise Induced Asthma	Albuterol Xopenex	2 puffs 1 vial (ampule)	Inhaler with spacer, if provided Nebulizer	Before exercise as needed to prevent symptoms					
	Asthma Yellow Zone	Albuterol Xopenex	**Please check one** 2 puffs 4 puffs 1 vial (ampule)	Inhaler with spacer, if provided Nebulizer	Every 4 hours as needed to relieve symptoms _____					
	Asthma Red Zone		**Call 911** 4 puffs 1 vial (ampule)	Inhaler with spacer, if provided Nebulizer	**For Emergency Symptoms**					
As Needed PRN Meds										

MD Stamp below

Physician Printed Name: _____ **Date:** _____ **Telephone:** _____

Physician Signature: _____ **Date:** _____ **Fax:** _____