MEDICATION AUTHORIZATION

IT'S ALL FUN & GAMES, LLC 1810 Valleybrook Dr Kingsville MD 21087

In order for your child to have ANY type of medication or to receive ANY medication at camp, (including, but not limited to **over-the-counter medications, inhalers, benadryl, or epi-pens**), we must have your physician's authorization and specific directions. It is required that the first dose of any medication be administered at home. All medications must be self-administered by the camper; including the ability to read the container as well as determine the correct amount. A responsible camp staff person will observe and supervise the child during this process.

We do not supply any over-the-counter medications. You may send medication to camp in the **original** or a **duplicate box or bottle** with the **current prescription label** on the container, accompanied by this completed form. (Upon request, pharmacists will label containers that can be used.) Have your physician complete this form and sign it. This form should be submitted to the camp office prior to the arrival of your child's medication.

Your permission and signature are also required with any medication. All forms and medication must be dropped off in the CAMP OFFICE!

PHYSICIAN'S INSTRUCTIONS FOR MEDICATION AT CAMP

Name of Camper _____ D.O.B. _____

Camper Address _____

Parents Primary Phone _____ Parent's Alternate Phone _____

Date of Commencement _____ Date of Discontinuation _____

Medication Name _____ Medication Dosage _____

Frequency of Administration _____ Route of Administration _____

If PRN, for what symptoms should the medication be administered _____

This medication is to be used for emergency situations Y N

Condition for which medication is being administered _____

If side effects or a reaction can be expected, please describe _____

_____

Please PRINT below the Physician's / Prescriber's Name, Title, Address, Phone Number and Fax Number:

_____ _____

_____

_____ _____

_____ _____

Physician's / Prescriber's Signature Date

AUTHORIZATION FOR SELF-MEDICATION

I authorize self-administration of the medication listed above, for the child named above, under the supervision of a designated staff member during the camp day. I request an authorized staff member at It's All Fun & Games, LLC to supervise the camper in self-administration if authorized as prescribed by the above authorized physician / prescriber. I certify that I have the legal authority to consent to medical treatment for the child named above, including self-administration by the child named above. I understand at the end of the authorized period, an adult must pick up the medication, otherwise it will be discarded. I authorize camp personnel to communicate with the authorized prescriber as allowed by HIPAA.

Physician's / Prescriber's Signature _____Date _____

Parent's Signature _____Date _____

MEDICATION FINAL DISPOSITION

IT'S ALL FUN & GAMES, LLC 1810 Valleybrook Dr Kingsville MD 21087

Parents, please complete only the Camper Information section of this page!

CAMPER INFORMATION

Name of Camper _____ D.O.B. _____

Camper Address _____

_____

Parent / Guardian's Primary Phone

_____

Parent/Guardian's Alternate Phone

_____

The bottom of this page is for camp staff use only.
Parents, please leave the following bottom section BLANK:

CAMP STAFF: COMPLETE AT END OF SESSION

1) Name of Medication (Listed on Reverse) _____

2) Date of Final Disposition of Medication Listed on Reverse _____

3) This medication was returned to the parent or guardian (Circle one) Y N (If No, skip Items #4 & #5)

4) Name of the person to whom the medication was returned _____

5) Name of the Camp Staff Member who returned the medication _____

6) Signature of the Camp Staff Member responsible for destroying the medication

_____ Date _____

7) Signature of the Person Witnessing the Destruction of the Medication

_____ Date _____