CAMP ROCKFISH
HEALTH PROGRAM
Request for Medication to be Given at Camp

TO BE COMPLETED BY HEALTH CARE PROVIDER

Name of Child_____ Date of Birth _____

Medication _____ Dosage _____
(No injection will be given except in extreme emergency, such as allergy to wasp or bee sting).

Time (s) medication is to be given: a.m. _____ p.m. _____
To be given from (date) _____ to _____

Significant Information (include side effects, toxic reactions, omission reactions) _____
_____.

Contraindications for Administration: _____
_____.

If an emergency situation occurs while the child is at the camp or if the student becomes ill, camp officials are to:

a) Contact me at my office. Phone _____
b) Take child immediately to the ER at _____
c) Other option _____

- Student **may not** self-administer medication.
- Student **may** self-administer medication (is able to carry medication on his/her person during school hours). Student is knowledgeable about medicine and when/how to use it.

_____ _____
Health Care Provider Signature Date

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PARENT PERMISSION

I hereby give my permission for my child _____ to receive medication while at Camp Rockfish. I hereby release the camp officials and their agents and employees from all liability that may result from my child taking the prescribed medication.

_____ _____ _____
Parent/Guardian Signature Phone Date

Reviewed by _____ _____
Camp Nurse Signature Date

4/16