

Please return to: Summer Roundup
PO Box 355
Bozman, MD 21612

amyschisler@me.com

Camper's Name: _____ DOB: _____

Health Care Recommendations by Licensed Medical Personnel (Physician, Physician's Assistant, or Nurse practitioner). Please attach immunization record.

BP _____ Weight _____ Height _____

I have examined the above camp participant and in my opinion his/her health status does ____/does not ____ preclude participation in an active camp program.

Is the applicant under the care of the physician for any conditions? If so, please list:

Recommendations and Restriction while at camp:

Medically prescribed meal plans or dietary restrictions:

Allergies:

Authorization for OTC Medications (to be completed by licensed personnel per State of MD requirements):

Medication	Indication	Yes	No	Allowable Dosage
Acetaminophen	h/a, cramps, minor discomfort	_____	_____	_____
Ibuprofen	h/a, cramps, minor discomfort	_____	_____	_____
Calcium carbonate	upset stomach, heartburn	_____	_____	_____
Anti-itch cream (cortisone)	bug bites, itching	_____	_____	_____
Calamine lotion/Calagel	bug bites, poison ivy	_____	_____	_____
Cough drops	cough, sore throat	_____	_____	_____
Diphenhydramine HCL	allergic reaction	_____	_____	_____
Hydrogen peroxide	minor cuts/scrapes	_____	_____	_____
Triple antibiotic ointment	minor cuts/scrapes	_____	_____	_____

Parent's signature _____ Date: _____

Prescriber's original signature/signature stamp (Parent cannot sign here):

_____ Date: _____

Printed Prescriber:

Prescriber address and phone number:

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MEDICATION ADMINISTRATION AUTHORIZATION FORM

I. CAMP OPERATOR

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self-administer medication. A new medication administration form must be completed at the beginning of each camp season, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by pharmacist or prescriber.
- Nonprescription medication must be in the original container with the instructions for use. Nonprescriptive medication includes vitamins, homeopathic, and herbal medicines.
- An adult must bring the medication to the camp and give the medication to an adult staff member.

II. CAMP INFORMATION

Summer Roundup Girl Scout Camp
25012 Beauchamp Branch Rd
Denton, MD 21629

III. PRESCRIBER'S AUTHORIZATION

NAME: _____ DATE OF BIRTH _____

CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED: _____ EMERGENCY MEDICATION [] YES [] NO

MEDICATION NAME _____ DOSE _____ ROUTE _____

TIME/FREQUENCY OF ADMINISTRATION _____ IF PRN, FREQUENCY _____

IF PRN, FOR WHAT SYMPTOMS _____ MEDICATION SHALL BE ADMINISTERED (not to exceed one year)
FROM _____ TO _____

PRESCRIBER'S NAME/TITLE _____

TELEPHONE _____ FAX _____

ADDRESS _____

PRESCRIBER'S SIGNATURE/STAMP (Parent Cannot sign here)

IV. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator/staff to administer the medication or supervise the camper in self-administration if authorized as prescribed by the above prescriber. I certify that I have legal authority to consent for medical treatment for the child named above, including the administration of medication at the facility. I understand that 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 prescriber as allowed by HIPAA.

PARENT/GUARDIAN SIGNATURE _____

DATE _____

HOME PHONE _____ CELL _____
PHONE _____ WORK _____

V AUTHORIZATION FOR SELF ADMINISTRATION AND SELF CARRY

I consent that the child named above is able to self-administer the medication listed. I authorize self-administration on of the above listed medication for the child named above under the supervision of an authorized youth camp operator/staff member. The child above may self-carry emergency medication listed below.

FOR EPI-PEN OR RESCUE INHALER ONLY (please attach action plan) SELF CARRY EMERGENCY MEDICATION (check one) [] YES [] NO

PRESCRIBER'S SIGNATURE _____

DATE _____

PARENT/GUARDIAN SIGNATURE _____

DATE _____

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NAME _____

CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:

EMERGENCY MEDICATION []YES []NO

MEDICATION NAME

DOSE

ROUTE

TIME/FREQUENCY OF ADMINISTRATION

IF PRN, FREQUENCY

IF PRN, FOR WHAT SYMPTOMS

MEDICATION SHALL BE ADMINISTERED (not to exceed one year)
FROM TO

PRESCRIBER'S NAME/TITLE

TELEPHONE

FAX

ADDRESS

PRESCRIBER'S SIGNATURE/STAMP (Parent Cannot sign here)

CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:

EMERGENCY MEDICATION []YES []NO

MEDICATION NAME

DOSE

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