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 ADMINISTARTION 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________________________

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PO Box 355
Bozman, MD 21612

amyschisler@me.com

PARENT/GUARDIAN SIGNATURE_______________________________________________ DATE_______________________________

NAME______________________________________________________________

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

MEDICATION NAME DOSE ROUTE

TIME/FREQUENCY OF ADMINISTARTION 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 ROUTE

TIME/FREQUENCY OF ADMINISTARTION 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)**