

Medication Administration Form

Nature Adventures Camp

Name of child _____

Name of medication _____

Please check one: Prescription: _____ Non-Prescription: _____

My child has previously taken this medication: Yes ___ No* ___

*If this is an emergency medication, I give permission for staff to give this medication to my child in accordance with his/her submitted individual health care plan. By signing below you agree to this statement.

Dosage: _____

Dates(s) medication to be given at camp: _____

Time(s) medication to be given at camp: _____

Reasons for medication: _____

Symptoms to watch for (if medication is to be given as needed): _____

Possible side effects of medication: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

Medication must be in its original container and accompanied by the prescription label.

Does your child need this medication for an **insect/food allergy**? Yes* ___ No ___ *If yes, please fill out the following:

Please indicate your child's allergy:

Insect (specify) _____

Food: (circle) Peanut Tree nut Milk Egg Fish Shellfish Wheat Soy

Other (specify) _____

Would your child have a reaction to skin contact with the allergen? Yes ___ No ___

Please share any other helpful information about your child in regards to his/her allergy: _____

I, _____, (parent or guardian) give permission to authorize Day Camp staff to administer medication to my child as indicated above.

Parent/Guardian Signature _____ Date _____