



FORM SHOULD BE RECEIVED BY JUNE 1ST OR AS SOON AS POSSIBLE

4-H CAMP WYOMOCO MEDICATION AUTHORIZATION

CAMPER: _____

CAMPER GENERAL HEALTH:

Explain any pertinent mental, emotional or social issues that camp staff should be aware of:

PARENT AUTHORIZATION REQUIRED (Epi-Pens, Inhalers, Sunscreen and Insect Repellant):

Has camper been trained in the proper use of the inhaler or epi-pen? ___Yes ___No
Parental consent for child to keep inhaler or epi-pen? ___Yes ___No
Parental consent for child to apply sunscreen and insect repellent: ___Yes ___No

Signature of Parent/Guardian: _____

Camp Wyomoco is NOT responsible for inhalers or epi-pens lost while in the camper's possession.

My child may receive medications, including supplements, over-the-counter and/or prescription medication:

- YES, my child's health-care provider has completed the sections below.
NO, please contact me in the event that my child needs medication. DO NOT complete the rest of this page.

Parent/Guardian Signature: _____ Date: _____

MEDICATION SECTION

TO BE COMPLETED BY THE CAMPER'S HEALTH CARE PROVIDER ONLY:
OVER THE COUNTER (OTC) MEDICATIONS AVAILABLE AT CAMP:

Table with 4 columns: Medication, Administer Order (Yes/No), Route, Dose / Time. Lists various OTC medications like Acetaminophen, Ibuprofen, etc.

OVER THE COUNTER (OTC) MEDICATIONS BROUGHT TO CAMP WITH CAMPER:

Table with 5 columns: Medication, Route, Dose, Time(s), Diagnosis. For OTC meds brought to camp.

PRESCRIPTION MEDICATIONS BROUGHT TO CAMP WITH THE CAMPER

Table with 5 columns: Medication, Route, Dose, Time(s), Diagnosis. For prescription meds brought to camp.

Prescription Medications (Please complete with camper's current regimen of scheduled medications, including inhalers. Attach additional page if needed.) All medications sent to camp must be in their original containers including inhalers which must come in their prescription labeled box. No pill boxes or unlabeled containers will be accepted.

NOTE: Prescription meds will only be administered as per the prescription label instructions.

- 1) The Camper is undergoing treatment at this time for the following condition (circle one): NONE YES (describe below)
2) Other treatments/therapies to be continued at Camp (circle one): NONE YES (describe below)
3) Do you feel that the camper will require limitations or restrictions at camp based on described treatments above (if YES is indicated above):

SIGNATURE OF PROVIDER:

Name of licensed provider (please print): _____ License No.: _____

Signature: _____ Title: _____ Telephone: _____ Date: _____

Office Address: _____