Authorization for Short Term/Long Term Prescription Medication

This form should be completed by parent/guardians who are requesting that the school assist in the administration of prescription medications such as antibiotics or daily medications.

Authorization to give long term/short term prescription medications

Summer at Sacred Heart requires the following:

1. A written consent form signed by the parent/guardian (this form)
2. The medication in the original bottle labeled by a registered pharmacist. (Note: Many pharmacists will give you additional bottles with labels if requested)
3. The parent/guardian to bring the consent and medication to the camp office/director.
4. Campers may self-carry inhalers, but all other medication and Epinephrine auto-injectors must be turned into the camp director. (This form must be filled out, signed and turned in even if self-carrying an inhaler.)

Student's Full Name____

Date of Birth____

Name of Medication____

Dosage____

Specific time(s) and dose(s) to be given at camp______________________________

Length of time____________________________ Why Indicated?_______________________

I request that the above mentioned camper receive the medication(s) listed above at camp according to standard camp policy and for the camp dirctor and camp staff to share information needed to assist my child with medication needs.

The camp recognizes that it may be necessary for some campers to administer/carry their own medications (inhalers only). Self-administration means that the student can administer the medication in a manner directed by a physician without additional direction or assistance by camp staff. Self-possession means that under the direction of the physician, the camper may carry medication on his/her person to allow for immediate and self-determined administration. Camper will need to notify camp staff each time camper self-administers medications. Camper also must understand the medication is for their use only and can not be given to other campers.

Parent/Guardian Signature___________________________________ Date__________________

Medication Summary / Kardex

PRN / As Needed Meds					
Date	Time	Medication	Dosage	Initials	Comments

Signature: ____ Initials: _______________

Signature: ____ Initials: _______________

Signature: ____ Initials: _______________

Signature: ____ Initials: _______________