Return to Danielle Lubbers (dlubbers@cbgsc.org) or upload to your Ultra Camp profile by June 1.

HEALTH CARE RECOMMENDATIONS BY MEDICAL PERSONNEL

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:

_____ _____

_____

Return to Danielle Lubbers (dlubbers@cbgsc.org) or upload to your Ultra Camp profile by June 1.

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

Camp Grove Point	**Camp Todd**	**Camp Country Center**	**Camp Sandy Pines**
2930 Grove Neck Road	**25012 Beauchamp Branch Road**	**1051 Sharpless Road**	**27157 Riverside Drive Extension**
Earleville, MD 21919	**Denton, MD 21629**	**Hockessin, DE 19707**	**Fruitland, MD 21856**

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)**

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

MEDICATION NAME DOSE ROUTE

Return to Danielle Lubbers (dlubbers@cbgsc.org) or upload to your Ultra Camp profile by June 1.

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)**

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

Return to Danielle Lubbers (dlubbers@cbgsc.org) or upload to your Ultra Camp profile by June 1.

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 PHONE_____

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_____