

Medication Administration Form

Camper's Name: _____

I understand that the Camp will make every reasonable effort to contact me or the authorized person(s) noted in a medical emergency. If the Camp is unable to reach us, I authorize the Camp Directors/ administration to designate a physician/hospital or other emergency personnel to initiate any appropriate medical services.

**THE FOLLOWING INFORMATION IS TO BE COMPLETED BY THE PHYSICIAN
IF THE CAMPER REQUIRES Prescription or Non-Prescription MEDICATIONs**

Name(s) of Medication(s): _____

Dosage(s): _____

If medication(s) is/are to be given DAILY, at what time? _____

If medication(s) is/are to be given PRN (AS NEEDED), describe: _____

Purpose: _____

Other significant information: _____

Note: In accordance with the law of the State of New Jersey, campers who self-medicate during the Camp day must bring the medication to the Director or camper's classroom teacher to be held in a secured location. These medications may be administered by the camper only in the presence of the Director, administrator and/or counselor, **must be in the original prescription bottle and clearly labeled in order to be dispensed, and accompanied with a copy of this form completed by the prescribing physician.** Controlled medications (e.g. Ritalin) require a 30 day physician's renewal.

Physician's Signature

Date

At the end of camp, medications must be picked up at school by the parent/guardian. Any remaining medication will be destroyed.

Parent/Guardian Signature

Date

Printed Name

