OIL BELT CHRISTIAN SERVICE CAMP
REQUEST FOR MEDICATION AT CAMP
(PRESCRIPTION AND NON-PRESCRIPTION)

CAMPER NAME_____GRADE_____BIRTHDATE___/___/_____

1. **NAME OF MEDICATION**:_____ DOSE : _____

   ROUTE: oral topical injection inhaler other_____ FREQUENCY 1 2 3 4 TIMES PER DAY.

   Any special times required???_____ PRN only

   POSSIBLE ADVERSE EFFECTS OF MEDICATION? YES NO if YES what?_____

2. **NAME OF MEDICATION**:_____ DOSE : _____

   ROUTE: oral topical injection inhaler other_____ FREQUENCY 1 2 3 4 TIMES PER DAY.

   Any special times required???_____ PRN only

   POSSIBLE ADVERSE EFFECTS OF MEDICATION? YES NO if YES what?_____

3. **NAME OF MEDICATION**:_____ DOSE : _____

   ROUTE: oral topical injection other_____ FREQUENCY 1 2 3 4 TIMES PER DAY.

   Any special times required???_____ PRN only

   POSSIBLE ADVERSE EFFECTS OF MEDICATION? YES NO if YES what?_____

4. **NAME OF MEDICATION**:_____ DOSE : _____

   ROUTE: oral topical injection inhaler other_____ FREQUENCY 1 2 3 4 TIMES PER DAY.

   Any special times required???_____ PRN only

   POSSIBLE ADVERSE EFFECTS OF MEDICATION? YES NO if YES what?_____

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NAME OF PHYSICAIN (WHO PRESCRIBED MEDICATIONS) TELEPHONE #

_____ _____

TO PARENT/ GUARDIAN:

Medications must be brought to camp in a container appropriately labeled by the pharmacy or physician. Nonprescription medications ordered by the physician should be brought with original label and the campers name affixed to the container. Only those medications which are necessary to maintain the camper in camp shall be administered. If you have any questions, please call the camp.

I hereby authorize the above named camp and its certified employees to act in my behalf to supervise the administration (or supervise self – administration) the medications prescribed above to my child. I acknowledge that a camp nurse may not be available to supervise the administration and specifically consent to certified camp employees giving the medication instead of the camp nurse

Date ___/___/_____ Signature of PARENT / GUARDIAN_____

HOME PHONE _____EMERGENCY / WORK PHONE _____

THIS FORM IS TO BE COMPLED EACH WEEK THE CAMPER REQUIRES MEDICATION TO BE GIVEN

CONFIDENTIAL INFORMATION