



# Beckwith

## CAMP MEDICATION FORM

Camper Name: \_\_\_\_\_

Camp Session: \_\_\_\_\_

Your camper's health and well-being during camp is of utmost importance to us! For us to treat and properly care for your child, we ask that you fully complete this form even if your child doesn't regularly take prescription or over-the-counter medication.

In addition to providing current prescription information there is room to provide information about OTC medicines **you will be providing** for your child while they are at camp. Our camp stock of OTC medicines is limited, so please provide anything you foresee your child needing during camp.

Please Note: All OTC medicines will be given following manufacturer's recommendations. If your child is younger than 12 and the medicine sent is not recommended for children younger than 12, a signed statement from the child's physician or health care provider authorizing administration of the OTC medicine will be necessary.

Suggested over-the-counter medicines: something for pain/fever [ex. children's Tylenol or Ibuprofen], something for allergy relief [ex. Benadryl], and something for upset stomach [ex. Pepto Bismol]. You may wish to consult with your child's physician or health care provider regarding what medication[s] to send.

If your child is bringing nasal sprays or inhalers and you wish your child to keep and self-administer them, then written authorization must be received from your child's physician.

I **DO** give permission for the camp nurse to provide my child over-the-counter (OTC) medication (i.e. aspirin, ibuprofen, Benadryl, Pepto-Bismol, essential oils, etc) we did not provide the nurse, to treat symptoms such as headaches, allergies, upset stomach, etc.

Parent/Legal Guardian of: \_\_\_\_\_

Parent/Legal Guardian (printed name) \_\_\_\_\_

Parent/Legal Guardian (signature) \_\_\_\_\_

Date: \_\_\_\_\_

I do **NOT** give permission for the camp nurse to provide my child over-the-counter (OTC) medication (i.e. aspirin, ibuprofen, Benadryl, Pepto-Bismol, essential oils, etc) we did not provide the nurse, to treat symptoms such as headaches, allergies, upset stomach, etc.

Parent/Legal Guardian of: \_\_\_\_\_

Parent/Legal Guardian (printed name) \_\_\_\_\_

Parent/Legal Guardian (signature) \_\_\_\_\_

Date: \_\_\_\_\_



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## CAMP MEDICATION FORM

### OVER THE COUNTER (OTC) MEDICATIONS:

\*\* A Parent or Legal Guardian may provide Camp with OTC medications. Please list below the medications you plan to send for your child and the reason(s) why your child should take them. All medication will be kept by the Camp Nurse. It must be in the **original manufacturer's container** with the camper's name written on the container. OTC medicines will be administered following manufacturer's guidelines.

Name of OTC Medicine

Reason(s) for Giving

Tylenol 160 mg (example)

According to manufacturer (example)

### PRESCRIPTION MEDICATIONS: The following section must be completed by camper's PARENT or LEGAL GUARDIAN.

(All medication is dispensed by a nurse) \* *If your child is bringing an EpiPen you MUST talk to us before your visit:*

List **all prescription medications** you plan to **send with your child** and the reasons s/he takes them (attach extra sheet if necessary)

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time Given \_\_\_\_\_ Reason \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time Given \_\_\_\_\_ Reason \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time Given \_\_\_\_\_ Reason \_\_\_\_\_

Your child's medication MUST be in the correct pharmacy prescription bottle w/ administration directions on the pharmacy label.

### Prescription medication label must include:

Child's name

Strength of the medication

Amount given

How often it is to be given

Expiration date of the medication.

*If you have any questions regarding our medication policies or to discuss ANY and ALL medical concerns, please contact*

*Rachel Gilliam, Program Director, at*

*(251) 928-7844 or rachel@BeckwithAL.com.*

Please accept this signature as my permission for the camp nurse to provide my child the over-the-counter (OTC) and/or prescription medication we have provided on this form.

Parent/Legal Guardian of: \_\_\_\_\_

Parent/Legal Guardian (printed name) \_\_\_\_\_

Parent/Legal Guardian (signature) \_\_\_\_\_

Date: \_\_\_\_\_