AUTHORIZATION FOR MEDICATION ADMINISTRATION

☐ Prescription

Must come in labeled container with the child's name, name of medicine, time medicine is to be given, dosage, route, date medicine is to be stopped, pharmacy name and phone number. The licensed Health Care Provider's name must also be included.

☐ Over-the-Counter / Non-Prescription

Must be labeled with the child's name. Dosage must match the signed Health Care Provider form, and medicine must be packaged in the original container. In accordance with state law, we are only able to administer medicines with written instructions from the child's physician. Email to: camp@aspensnowmass.com

The parent/ guardian of (child's name) _____

ask that the care staff at Camp Aspen Snowmass / Snow Cubs give the following medication (write the name of medication, dosage and time to be given here) _____

to my child, according to the Health Care Provider's signed instructions on the *other side* of this form.

Signature of Parent/ Guardian: _____ Date: _____

Printed Name: _____ Phone: _____

☐ Self – Administration and/ or Self – Carry

Children may follow self-care procedures ONLY if the Prescription, Over-the-Counter / Non-Prescription Form on the other side of this page is complete. This includes Health Care Provider Authorization and all necessary signatures. Children will not be permitted to take medication during camp hours without the necessary paperwork on file.

The parent/ guardian of (child's name) _____

authorizes permission for my child to be responsible for the following medication (write the name of medication, dosage and time to be given here) _____

according to the Health Care Provider's signed instructions on the *other side* of this form.

How and where will the medication be stored? _____

Does your child need reminders, assistance in any way, or help? If so, please explain: _____

_____

Signature of Parent/ Guardian: _____ Date: _____

Signature of Child: _____ Date: _____

☐ Food Allergy ☐ Special Diet ☐ Other: _____

If your child has an allergy that requires a prescription or is an over-the-counter medication, the other side of this page must be completed. This includes Health Care Provider Authorization and all necessary signatures.

The parent/ guardian of (child's name) _____

ask that the care staff at Camp Aspen Snowmass / Snow Cubs accommodate the following (write the allergy, preference or need here) _____ .

If applicable, explain symptoms, severity of allergy, and last episode: _____

_____

Treatment if necessary: _____

Does your child need reminders, assistance in any way, or help? If so, please explain:

Signature of Parent/ Guardian: _____ Date: _____

AUTHORIZATION FOR MEDICATION ADMINISTRATION

HEALTH CARE PROVIDER AUTHORIZATION

Child's Name: _____ Date of Birth: _____
Name of Medication: _____ Time(s) to be given: _____
Refrigeration: Y / N Start-End Dates: _____ Dosage:_____
Route: _____ Reason for Medication: _____
Last Episode: _____ Possible Side effects: _____
Medication Exp. Date: _____ Special Instructions: _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority *Date*

_____ _____
Print Name of Health Care Provider *Phone*

WRITTEN MEDICATION LOG for Staff

** Only those certified in Medication Administration are allowed to administer medication.*

Date	Child's Name	Medication	Dose	Time	Given by	Staff Signature

For office use only:

Camp Aspen Snowmass / Snow Cubs will make all reasonable accommodations under ADA federal law.
They are listed here: _____
_____
_____

The appropriate Care Plan must be attached:

☐ Asthma Care Plan ☐ Diabetes Care Plan ☐ Epi-Pen Care Plan ☐ Special Diet / Special Accommodation Form
☐ Medical Condition Accommodations ☐ Other Plan: _____

Further training required by staff: Circle Y / N If yes, list date and training here: _____

All medication returned to parents and/ or guardian on: _____ Staff initials here: _____

_____ _____
Signature of Child Care Health Consultant, Karin Bannerot, RN, MSN *Date*