

## CAMP COLLEGE MEDICATION REQUEST

\*\*\*PLEASE ATTACH A RECENT PHOTO OF YOUR CHILD\*\*\*

I request Camp College staff to administer the medication described below to my child:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Amount to be administered: \_\_\_\_\_ Time(s) to be given: \_\_\_\_\_

Reason: \_\_\_\_\_  
\_\_\_\_\_

Side effects: \_\_\_\_\_ Parent/Guardian Phone Number: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IMPORTANT – PLEASE READ:** Administering medication is discouraged; however, some children with various illnesses and disabilities will require medication during camp hours. If medication must be administered, please complete and sign this form for **each** medication, including over-the-counter drugs.

**Notify the camp nurse in writing if there is a change in the medication, or if it should be discontinued. Medication must be delivered in the original container**, appropriately labeled by the pharmacy or physician, and handed to a camp administrator or nurse **with a completed and signed copy of this form and A RECENT PHOTO OF YOUR CHILD**. The medication will be held in the health office and must be taken by the camper under staff supervision. **(Medications that a child must carry throughout the day for self-administration must have a completed *Camper Self-Medication Permission*.)**

**PHYSICIAN SIGNATURE REQUIRED** \_\_\_\_\_

*Health Office – SC 141 \* Telephone (609) 570-3777*

## CAMP COLLEGE SELF-MEDICATION PERMISSION

\*\*\*PLEASE ATTACH A RECENT PHOTO OF YOUR CHILD\*\*\*

*Complete this section only if self-medication is required*

Camper's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Camp Session or Program: \_\_\_\_\_

### PARENT/GUARDIAN AUTHORIZATION

My child has a physical condition which requires him/her to receive medication as quickly as possible in order to avoid a medical crisis. In the interest of his/her personal well being, I hereby grant my child the authority to carry his/her medication \_\_\_\_\_ and to self-administer it as directed by the prescribing physician when needed.

Name of Medication \_\_\_\_\_ Dose/Amount \_\_\_\_\_

Condition requiring self-medication: \_\_\_\_\_

In granting this permission for my child to self-medicate, I hereby absolve Mercer County Community College and all its employees from any liability or legal responsibility for any condition that may arise from the administration or lack of administration of such medication.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PHYSICIAN'S AUTHORIZATION

The above-named patient must use \_\_\_\_\_ by self-administration. He/she has been instructed in its proper use.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Note:** A completed and signed copy of this form must be given to the camp director or nurse no later than the first day of camp or the first day that the child brings the medication to camp. (609)570-3777.