WESTMARK SCHOOL'S Camp Funtime

## REQUEST FOR MEDICATION TO BE TAKEN DURING CAMP HOURS

To be filled out by prescribing physician **ONLY.** No prescription medications may be given without a signature from the physician. There are NO exceptions. Parents are responsible for supplying all medications in their original containers. For the safety of all students, students are not to carry any medication (prescription or non-prescription) with them. All medication must be delivered to the health office. Please complete **one form** per medication.

Camper Name: _____ _____ _____ _____
Last First Sex DOB

Condition requiring medication: _____
_

Name of Medication: _____ Dosage Prescribed: _____

Time to be Given: _____ Frequency: _____

Method of Administration: _____ Discontinue on this date_____
(Oral, Injection, Inhalant)

Side Effects: _____

Special Instructions and/or Comments:_____

Does camper have permission to decline medication? Y N
If yes, under what
circumstance?_____

**Physician Signature: The camper for whom this medication is prescribed is under my care.**

_____ _____ _____
Print name of Licensed Physician Signature of Licensed Physician Date

_____ _____
Address Telephone

**Parental Authorization**
I authorize the camp nurse or other camp personnel, to administer the medication as directed by the authorized health care provider. I understand that the camp nurse has my permission to communicate with the prescribing licensed health care provider on matters related to this medication.

_____ _____
Parent/Guardian Print Name Signature Date

_____ _____
Parent/Guardian Print Name Signature Date