



MEDICATION INFORMATION FORM (cont.) NAME \_\_\_\_\_ DOB \_\_\_\_\_

PLEASE NOTE ANY SPECIFIC INSTRUCTIONS REGARDING ADMINISTRATION OF MEDICATION

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PLEASE NOTE ANY INSTRUCTIONS REGARDING POSSIBLE SIDE EFFECTS, DURATION OF TIME TO BE ADMINISTERED (i.e. 10 days, until finished, etc.)

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Did this person bring any over-the-counter medications or treatments? This includes Tylenol, Advil, cough syrup, vitamins, medicated creams such as Triple Antibiotic, Hydrocortisone, etc. Yes \_\_\_ No \_\_\_ Please list these and describe when and how administered. (Please note: Any item with a prescription label must be listed on the front of this form and include physician's signature. If your camper is under 18, you will need a physician's signature on the front of this form for over-the counter items.)

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Attention: This form will be returned to you if it is not filled out correctly and signed-please check it carefully. *If changes are made in your camper's medication regimen once this form is completed, you are responsible for providing accurate updates or your camper may not be allowed to stay. (Keep a copy and recheck it before your camper comes to camp.)*

- ➔ **This form must include all medications and treatments prescribed to this camper- this includes lotions, inhalers, liquids, allergy medications, cold medications, temporarily prescribed meds. Sample medications will not be administered without the proper prescription label.**
- ➔ **Each medication listed must include accurate dosages, times and instructions.**
- ➔ **Each prescribed medication or treatment must be signed by the prescribing physician.**
- ➔ **Any changes in dose, time, frequency must be accompanied by a written physician's order or a new form.**
- ➔ **Any medication that has been added must be accompanied by a written physician's order or a new form.**
- ➔ **Any medication that has been discontinued must be accompanied by a written physician's order or a new form.**
- ➔ **Labels on medication containers must match this medication information form.**
- ➔ **No foreign prescriptions without proper labeling.**

IT IS THE PARENT/PROVIDER or GUARDIAN'S RESPONSIBILITY TO INSURE THAT ALL PRESCRIBING PHYSICIANS ARE AWARE OF ALL MEDICATIONS PRESCRIBED TO THIS CAMPER AND THAT NO CONTRA-INDICATIONS OR INTERACTIONS EXIST.

I CERTIFY THAT I HAVE READ THIS INFORMATION AND WILL FOLLOW THE GUIDELINES. I UNDERSTAND THAT FAILURE TO FOLLOW THESE GUIDELINES MAY RESULT IN MY CAMPER NOT BEING ALLOWED TO STAY AT CAMP.

SIGNATURE OF PERSON TAKING RESPONSIBILITY \_\_\_\_\_

NAME AND RELATIONSHIP TO CAMPER PRINTED \_\_\_\_\_

**THIS FORM IS VALID FOR TWO YEARS  
IF ACCURATE**