Camp Medication Permission Form

Jenison Public Schools – Bursley 2015 - 2016

Child's Name: _____ Age: _____

Child's Teacher: _____ Birth Date: _____

Weight: _____

Parent/guardian Permission:

I request that the above named receive the medications listed below at camp according to standard school policy. I also give my permission for the physician(s) and camp staff to share information regarding my child's medication and/or medical condition on a need-to-know basis.

Date:_____ **Signature:**_____

Your relationship to child:_____

***Prescription drugs** must be in a **labeled container** as prepared by a pharmacy, physician, or pharmaceutical company and labeled with dosage and frequency of administration.

***Non-prescription drugs** must be in the **original pharmaceutical container**.

MEDICATION 1:

1. **Name:**_____ Expiration Date: (if applicable) _____

❒ Tablets/capsules - Mg_____ (each tablet)

(# given to nurse) _____ ***Needed for Prescription meds only**

❒ Injection ❒ Inhaler ❒ Nebulizer

❒ Liquid ❒ Other_____

❒ **Non-Prescription Instructions:**

(include dose, frequency, under what circumstances it is to be given, etc.)

_____

_____

❒ **Prescription**

Physician's Name:_____ Phone Number: _____

Instructions (as written/prescribed by physician):

_____

_____

Physician's Name:_____ Phone Number: _____

Instructions (as written/prescribed by physician):

_____

_____

OVER PLEASE FOR MORE MEDICATION DESCRIPTIONS

MEDICATION 2:

2. Name:_____ Expiration Date: (if applicable) _____

❒ Tablets/capsules - Mg_____ (each tablet)
(# given to nurse) _____ ***Needed for Prescription meds only**
❒ Injection ❒ Inhaler ❒ Nebulizer
❒ Liquid ❒ Other_____

❒ **Non-Prescription Instructions:**
(include dose, frequency, under what circumstances it is to be given, etc.)
_____
_____

❒ **Prescription**
Physician's Name:_____ Phone Number: _____
Instructions (as written/prescribed by physician):
_____
_____

MEDICATION 3:

3. Name:_____ Expiration Date: (if applicable) _____

❒ Tablets/capsules - Mg_____ (each tablet)
(# given to nurse) _____ ***Needed for Prescription meds only**
❒ Injection ❒ Inhaler ❒ Nebulizer
❒ Liquid ❒ Other_____

❒ **Non-Prescription Instructions:**
(include dose, frequency, under what circumstances it is to be given, etc.)
_____
_____

❒ **Prescription**
Physician's Name:_____ Phone Number: _____
Instructions (as written/prescribed by physician):
_____
_____

MEDICATION 4:

4. Name:_____ Expiration Date: (if applicable) _____

❒ Tablets/capsules - Mg_____ (each tablet)
(# given to nurse) _____ ***Needed for Prescription meds only**
❒ Injection ❒ Inhaler ❒ Nebulizer
❒ Liquid ❒ Other_____

❒ **Non-Prescription Instructions:**
(include dose, frequency, under what circumstances it is to be given, etc.)
_____
_____

❒ **Prescription**
Physician's Name:_____ Phone Number: _____
Instructions (as written/prescribed by physician):
_____
_____