GLEN HELEN ECOCAMP MEDICATION ADMINISTRATION FORM

Child’s Name __________________________ Age __________________
Camp(s) ______________________________ Week #(s) __________________

Guidelines
• If your child is coming with any medication, vitamins or supplements, this form must be completed in full.
• A physician’s signature is required for all prescription medications.
• A physician’s signature is also required for all non-prescription medications that are to be administered at a different dosage or schedule than recommended by the drug manufacturer.
• Medications must be in their original containers with the child’s name, dosage and schedule listed.
• Bring medications in a clear zip lock bag clearly labeled with your child’s name and camp.
• Medication can be dispensed five times during each day: 8:00 am, 12:00 pm, 3:20 pm, 6:00 pm, and 9:00 pm.
• If your camper’s medication dosage must be specific to a non-listed time or they are attending a Night Camp, please discuss the dosage schedule with a staff member on registration day.

Please list all prescription and non-prescription medications being brought to Glen Helen:
1. Name of medication: __________________________ Purpose of medication: __________________________ Dosage and dispensing times: __________________________
2. Name of medication: __________________________ Purpose of medication: __________________________ Dosage and dispensing times: __________________________
3. Name of medication: __________________________ Purpose of medication: __________________________ Dosage and dispensing times: __________________________
4. Name of medication: __________________________ Purpose of medication: __________________________ Dosage and dispensing times: __________________________

Parent/Guardian Signature __________________________ Date __________
Parent/Guardian Printed Name __________________________ Phone Number __________________________

FOR PRESCRIBING PHYSICIAN

I have approved the above information regarding prescription medications or non-prescription medications with dosage variations.

Physician’s Signature __________________________ Date __________
Physician’s Printed Name __________________________ Phone Number __________________________