

Day and Evening Camp 2019: Specialized Health Care Plan: Asthma Action Plan

Medication Authorization

Necessary for ALL prescription and Non-prescription medications administered at camp

Medication Name: <input type="checkbox"/> Prescription <input type="checkbox"/> Non <input type="checkbox"/> EMS	Dosage/Strength:	Type of Device:
Time Given: (For what symptoms)	Time Interval/ Repeating Dose:	Relevant side effects: (Specify) <input type="checkbox"/> none expected

Medication Name: <input type="checkbox"/> Prescription <input type="checkbox"/> Non <input type="checkbox"/> EMS	Dosage/Strength:	Type of Device:
Time Given: (For what symptoms)	Time Interval/ Repeating Dose:	Relevant side effects: (Specify) <input type="checkbox"/> none expected

Medication Name: <input type="checkbox"/> Prescription <input type="checkbox"/> Non <input type="checkbox"/> EMS	Dosage/Strength:	Type of Device:
Time Given: (For what symptoms)	Time Interval/ Repeating Dose:	Relevant side effects: (Specify) <input type="checkbox"/> none expected

Medication shall be administered during the year in which this form is dated below, unless more restrictive dates are specified here: From: ___/___/_____ To: ___/___/_____ (This authorization is not to exceed 1 YEAR.)

Authorization for Administration of Emergency Medication

Please note the prescriber, the parent/guardian and the Camp Health Staff must authorize self-administration. Additionally, while at camp, all emergency medications will remain with a counselor, in the camper's unit/group's first aid kit and available to the camper at all times.

Health Care Provider Authorization (REQUIRED): I authorize the administration of the medications as ordered above.

PRESCRIBER'S SIGNATURE **	DATE
PRESCRIBER'S NAME AND TITLE	PRESCRIBER'S PHONE
PRESCRIBER'S ADDRESS	
"I authorize self-administration of the above listed medication for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer."	SELF-ADMINISTER EMS MEDICATIONS <input type="checkbox"/> Yes <input type="checkbox"/> No

Parent/Guardian Authorization

I hereby authorize the camp staff to administer the treatments, procedures and medications or to supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I hereby release Girl Scouts Nation's Capital, their agents, and employees from any liability that may result from my child taking the prescribed medication. I understand that I must provide all medications/devices enclosed in this plan and that at the end of the authorized period an authorized individual must pick up the medication/devices; otherwise, it will be discarded.

PARENT/GUARDIAN SIGNATURE	DATE
"I authorize self-administration of the above listed medication for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer."	SELF-ADMINISTER EMS MEDICATIONS <input type="checkbox"/> Yes <input type="checkbox"/> No

**Please Complete
this form in Camp
Docs**

I have reviewed the camper's plan for completeness and have consulted the camper's parent/guardian, authorized prescriber, and/or the camp's health director for further questions and consultation if needed.

Camper may self-administer the above listed medication within camp Yes No

Camp Health Staff: _____ Date _____