girl scouts nation's capital

DO NOT MAIL THIS FORM – BRING IT WITH YOU **TO CAMP** OR **THE BUS STOP**

COMPLETE THIS FORM FOR **Camp Brighton Woods, Camp Tuckerman, Camp Sunshine, and Sweet Little Vacation ONLY**

Day & Evening Camp 2019
Bringing Medication to Camp
Form B

Camp Brighton Woods, Camp Tuckerman, Camp Sunshine and Sweet Little Vacation **ONLY**

Due to Maryland Youth Camp Regulations, this form must be completed by **a parent/guardian and a physician.**

Camper's Name: ______________________________________

Date of Birth: _____/_____/__________ Age: _______

Address: ____

City: ______________ State: __________ Zip: _________

Name of Camp: ______________________________________

Unit: ____________________

☐ Camper is attending more than one Day & Evening Camp program this summer.

This form must be completed fully in order for camp staff members to administer the required medication or for the camper to administer the medication. A new medication administration form must be completed at the beginning of each camp season, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in the labeled original container by the pharmacist or prescriber.
- DO NOT pre-dispense, place in a daily pill holder, wrap in outer materials, or ask us to dispense by other than doctor's order.
- At least one dose of a prescription medicine MUST be given to the camper at home before bringing to camp.
- Please indicate if medicine is taken daily or as needed.
- Please be specific with any variation or conditions associated with "as needed". (PRN)
- If you daughter will bring an **inhaler, EpiPen,** or other emergency med to camp, or has **diabetes** please also complete the **Specialized Health Care Form** and **Action Plan** or copy of current approved action plan.
- Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.
- An adult must bring the medication to the camp or bus stop and give the medication to an adult staff member.

Must be completed for campers bringing medication to camp

Medication Name: ☐ **Prescription** ☐ **Non**	**Dosage:**	**Reason medication is being administered:**	**Date Taken at Home:**
Time/Frequency: ☐ **Breakfast** ☐ **Lunch** ☐ **Dinner** ☐ **Bedtime** ☐ **Time:____ am/pm** **If PRN: every _______ hrs For what symptoms:** **Route of Administration:**		**Relevant side effects:** ☐ **none expected** **Specify:**	
Medication Name: ☐ **Prescription** ☐ **Non**	**Dosage:**	**Reason medication is being administered:**	**Date Taken at Home:**
Time/Frequency: ☐ **Breakfast** ☐ **Lunch** ☐ **Dinner** ☐ **Bedtime** ☐ **Time:____ am/pm** **If PRN: every _______ hrs For what symptoms:** **Route of Administration:**		**Relevant side effects:** ☐ **none expected** **Specify:**	
Medication Name: ☐ **Prescription** ☐ **Non**	**Dosage:**	**Reason medication is being administered:**	**Date Taken at Home:**
Time/Frequency: ☐ **Breakfast** ☐ **Lunch** ☐ **Dinner** ☐ **Bedtime** ☐ **Time:____ am/pm** **If PRN: every _______ hrs For what symptoms:** **Route of Administration:**		**Relevant side effects:** ☐ **none expected** **Specify:**	

Medication Name: ☐ Prescription ☐ Non	Dosage:	Reason medication is being administered:	Date Taken at Home:
Time/Frequency: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Time:____ am/pm If PRN: every ______ hrs For what symptoms: Route of Administration:		Relevant side effects: ☐ none expected Specify:	

Medication Name: ☐ Prescription ☐ Non	Dosage:	Reason medication is being administered:	Date Taken at Home:
Time/Frequency: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Time:____ am/pm If PRN: every ______ hrs For what symptoms: Route of Administration:		Relevant side effects: ☐ none expected Specify:	

Medication Name: ☐ Prescription ☐ Non	Dosage:	Reason medication is being administered:	Date Taken at Home:
Time/Frequency: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Time:____ am/pm If PRN: every ______ hrs For what symptoms: Route of Administration:		Relevant side effects: ☐ none expected Specify:	

Medication Name: ☐ Prescription ☐ Non	Dosage:	Reason medication is being administered:	Date Taken at Home:
Time/Frequency: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Time:____ am/pm If PRN: every ______ hrs For what symptoms: Route of Administration:		Relevant side effects: ☐ none expected Specify:	

Additional Comments:

Licensed Medical Professional/Prescriber section:

*Necessary for **ALL** prescription and Non-prescription medications administered at <u>Camp Brighton Woods, Camp Tuckerman, and Sweet Little Vacation</u>*

Name:____ **Title:** ____

Address:____ **Telephone:** (_____) ____________ **Fax:** (_____)____________

Street Address City State Zip

Signature:____ **Date:** ______________________

Licensed Medical Professional/Prescriber Stamp

Parent/Guardian Section:

I request the authorized youth camp operator, staff member or volunteer to administer the medication or 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 understand that at the end of the authorized period, an authorized individual, which may include the child, must pick up the medication, otherwise it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

Parent/Guardian Name:________________________________ **Telephone 1:** (_____) ___________ **Telephone 2:** (_____) ____________

Signature:____ **Date:** ______________________

(Please copy this page, as needed, for additional medications.)