CITY OF UPPER ARLINGTON

REQUEST FOR ADMINISTRATION OF MEDICATION AT SUMMER DAY CAMP

Day Camp Location: (circle one) Thompson Reed Barrington SNACK

Box 1	The following section must always be completed by the parent/guardian

Check all that apply and complete all of the information

- ☐ Prescription Medication
- ☐ Nonprescription Medication
- ☐ Food Supplement
- ☐ Refrigeration Required
- ☐ Modified Diet

Name of Child	Date of Birth	Weight

Name of Medication	Exact Dosage

To be administered at the following times	For the following period of time

- ☐ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

Signature of Parent/Guardian	Date

Box 2	**If any of the conditions below apply, the following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.**

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a non-prescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescriptive label.
4. The non-prescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The medication is prescribed and is in the original pharmacy dispenser container.

Name of child	Name of medication, vitamin, diet, supplement

Dosage	Possible side effects to watch for are

Expiration Date
(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.
Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

_____ _____

Signature Printed Name of Physician

Date of signature	Phone number

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Prescribed Medication Authorization

A new form must be completed for each dosage/medication/doctor change.

Camper Name _____ Birth Date_____

Address_____Camp Location (circle) **Thompson Barrington Reed SNACK**

To the Parent/Guardian:

The following information is necessary for any Day Camp participant who receives and/or uses prescribed medications at Camp. Both portions of this form must be completed for acceptance.

1. I request permission for my child (named above) to receive or use medication according to the physician's verification below.
2. I assume responsibility for safe delivery and adequate supply of medication to Summer Day Camp/SNACK Camp.
3. I will provide a written statement if my child is no longer to receive medication at Summer Day Camp.
4. I understand it is my responsibility to retrieve medication by August 24, 2018. If I do not retrieve medication before this date, I understand that medication will be destroyed.
5. I agree to complete and have a physician complete a new form should dosage/medication/physician changes occur.
6. I,(undersigned) release and agree to hold the City of Upper Arlington and its employees, officials and directors, harmless for any and all liability for damages and/or injury resulting directly or indirectly from this authorization.

_____ _____

Parent/Legal Guardian Signature Parent/Legal Guardian Printed Name

_____ _____

Primary Phone Number Secondary Phone Number

Box 3	The follow section must be completed by the designated person administering medication for the child listed on page one of this form. All medication must be documented when administered.		
Date	Time	Dosage	Signature of Designated Person Administering Medication

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.