## **Medication Administration Permission Form**

	This form	<b>must</b> be given to the Place			ent Camp check n in a zip-lock ba		return to GSLE!
Campe	r's Name				_ Camp Sessi	on	
		Last name	First Nam	e	Dates of Ses	sion	
Emergen	cy Contact:				Phone 1 (	)	
		Last name	First Nam	e	Phone 2 (	)	
All me	dications an	d this form are to b	e given to camp	o staff upon	arrival at camp	. Please do	not pack medications
This ind If your listed o contain	cludes all ov child is takin n this form. er. <u>* <b>Most o</b></u>	er the counter medications to can Review with Health	ations such as as np they must be Supervisor upon dication (aspiring	pirin, Tylen clearly mar check in. A n, Tylenol, l	ol, ointments and ked with her nam ll medications mu	vitamins, A e and the n ust be sent	e camp Health Supervisor AND prescription drugs. ame of the medication to camp in the original and at all camps and
If sever		action occurs – is Ep oin must be included			] No		
	Camper h Camper re injections Specify:	as permission to se as Epi-pen and has equires assistance f , testing blood suga	permission to rom personnel ar, etc.)	self-admini specifically	ster as needed a trained to perfe	nd is resp	
	Camper is	bringing the follow	wing medical e	<i>quipment</i> t	o camp:		
		as permission to re hich medicines she		counter me	dications such a	s Tylenol,	Benadryl, etc, please
	Camper C	ANNOT take the f	following medi	cations:			
	Camper h	as dietary needs (li	st restrictions -	- NOT pref	erences). PLEA	SE BE SP	ECIFIC!!!!!!
	The me	edications indicated	on this form a	re to be adn	ninistered to my	camper w	hile at camp.
Counci appropi	l's staff and/ riate under th	or leadership to obta	in and/or provid connection with	e medical tro my authoriz	atment and servi ation, I understar	ces deemed	ana East, I authorize the I necessary and nsurer of the Girl Scouts
Parent	/Guardian			/			Date
		(please	print)	;	(signature)		

Special comments / instructions (if necessary)/ Please let us know if your camper wets the bed, sleep walks, or has frequent occurrences that we should be aware:

CAMP USE ONLY
Incoming Temperature:
Lice Check:



PARENT USE	CAMP USE ONLY—INDICATE TIME ADMINISTERED AND INITIAL								
Medication 1	Time:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday		
Name of Medicine: Prescribed for:	BREAKFAST								
Dosage:	LUNCH								
How often:	DINNER								
Comments:	NIGHTTIME								

PARENT USE	CAMP USE ONLY—INDICATE TIME ADMINISTERED AND INITIAL								
Medication 2	Time:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday		
Name of Medicine: Prescribed for:	BREAKFAST								
Dosage:	LUNCH								
How often:	DINNER								
Comments:	NIGHTTIME								

PARENT USE	CAMP USE ONLY—INDICATE TIME ADMINISTERED AND INITIAL								
Medication 3	Time:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday		
Name of Medicine: Prescribed for:	BREAKFAST								
Dosage:	LUNCH								
How often:	DINNER								
Comments:	NIGHTTIME								

PARENT USE	CAMP USE ONLY—INDICATE TIME ADMINISTERED AND INITIAL								
Medication 4	Time:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday		
Name of Medicine: Prescribed for:	BREAKFAST								
Dosage:	LUNCH								
How often:	DINNER								
Comments:	NIGHTTIME								