CAMP COLLEGIUM
ADMINISTRATION OF MEDICATION

STUDENT NAME:_____ **GRADE**:_____

PARENT/GUARDIAN NAME:_____

I (WE) GIVE PERMISSION FOR THE NURSE TO ADMINISTER:

TYLENOL_____   ANTACID_____

DIAGNOSES	**MEDICATION**	**DOSAGE**	**TIME**	**ROUTE**

_____

_____

_____

_____

POSSIBLE SIDE EFFECTS: (PLEASE CIRCLE)

ANOREXIA   SEDATION   AGITATION   ANXIETY   CONSTIPATION   NAUSEA

VOMITING   HEADACHE   DRY EYE   FATIGUE   DIZZINESS   DIARRHEA

OTHER: _____

SPECIAL INSTRUCTIONS:_____

ADMINISTER UNTIL:_____

MEDICATION/DRUG ALLERGIES:
_____

PERTINENT ADDITIONAL INFORMATION:
_____
_____

I(WE)GRANT PERMISSION FOR THE CAMP NURSE TO COMMUNICATE WITH THE HEALTH CARE PROVIDER REGARDING MEDICATION CONCERNS.

HEALTH CARE PROVIDER: _____

HEALTH CARE PROVIDER SIGNATURE:_____
DATE:_____

Medical Insurance Company: _____
Policy Number:_____

PARENT/GUARDIAN SIGNATURE: _____
DATE:_____

DAILY PRESCRIPTION,TEMPORARY/SHORT-TERM AND HOMEOPATHIC MEDICATION

- A Health Care Provider's (MD/DO/CRNP)note **MUST** accompany the medication, including date, time of medication, and dosage. A pharmacy label and /or a stamped order **DO NOT** meet the state requirements of a written HCP's signature.
- A parent/guardian note and/or signature requesting medication administration as prescribed by the HCP **MUST** be provided.
- Medication must be clearly labeled in the original, most current container from the pharmacy and **MUST** include:
  Student's name, medication, dosage
  Instructions for administration
  Health Care Provider's name

NON-PRESCRIPTION MEDICATION

- A parent/guardian note requesting the medication administration with instructions **MUST** be provided.
- Medication **MUST** be in the original container. The expiration date **MUST** be evident.

NO MEDICATION WILL BE ADMINISTERED UNLESS THE ABOVE DIRECTIONS ARE FOLLOWED.

M-12B Revised 2/16