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| **I. CAMP OPERATOR** | | | | | | | | | | | | | | |
| **Please complete this form completely. For your child to have medication at camp and for our medical staff to be allowed to supervise your child while self administering medication please make sure that medications:**   * **Prescription medications are in the original container labeled by the pharmacist or prescriber.** * **Nonprescription medication is in the original container with instruction son them. Nonprescription medications include: vitamins, homeopathathic, and herbal medications.** * **One form per medication needed while at camp.** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **II. CAMP INFORMATION** | | | | | | | | | | | | | | |
| **YOUTH CAMP NAME:** Coach Wootten’s Basketball Camp | | | | | | | | | | | | | | |
| **PHYSICAL ADDRESS:** Bishop O’Connell High School: 6600 Little Falls Road | | | | | | | | | | | | | | |
| **CITY:** Arlington | | | **STATE:** VA | | | | | | | | | **ZIPCODE:** 22213 | | |
| **III. PRESCRIBER’S AUTHORIZATION** | | | | | | | | | | | | | | |
| **CHILD’S NAME:** | | | | | | | | DATE OF BIRTH: | | | | | | |
| **CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:** | | | | | | | | | | | **EMERGENCY MEDICATION**  **YES** **NO** | | | |
| **MEDICATION NAME:** | | | | | **DOSE:** | | | | | | **ROUTE:** | | | |
| **TIME/FREQUENCY OF ADMINISTRATION:** | | | | | | | | | | | **IF PRN, FREQUENCY:** | | | |
| **IF PRN, FOR WHAT SYMPTOMS:** | | | | | | | | | | | | | | |
| **KNOWN SIDE EFFECTS SPECIFIC TO CHILD:** | | | | | | | | | | | | | | |
| **MEDICATIN SHALL BE ADMINISTERED**  **(NOT TO EXCEED 1 YEAR)** | | | | **FROM:** | | | | | | **TO:** | | | | |
| **PRESCRIBER’S NAME/TITLE** | | | | **PRESCRIBER’S ADDRESS STAMP** | | | | | | | | | | |
| **TELEPHONE:** | **FAX:** | | |
| **ADDRESS** | | | | **CITY:** | | | | | **STATE** | | | | | **ZIPCODE** |
| **PRESCRIBER’S SIGNATURE:**  **(stamp permitted)** | | | | | | | | | | | | | | |
| **IV. PARENT/GUARDIAN AUTHOIRZATION** | | | | | | | | | | | | | | |
| **I request authorized Morgan Wootten, INC medical staff/employees/camp operator to supervise/administer the medication as prescribed by the above 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 authorization period, an adult must pick up the medication at the end of camp week, otherwise it will be discarded. I authorize camp personnel to communicate with the prescriber as allowed by HIPPA. I confirm that, if the medication above is a prescription medication, the child has at some point taken the medication prior to attending camp.** | | | | | | | | | | | | | | |
| **PARENT/GUARDIAN SIGNATURE:** | | | | | | **DATE:** | | | | | | | | |
| **HOME PHONE #:** | | | | | | | **CELL PHONE #:** | | | | | | | |
| **V. AUTHORIZATION FOR SELF ADMINISTRATION AND SELF CARRY** | | | | | | | | | | | | | | |
| I consent that the child named above is able to self-administer the medication listed. I authorize self administration of the above listed medication for the child named above under the supervision of an authorized youth camp operator/staff member. The child named above may self carry emergency medication if indicated below. | | | | | | | | | | | | | | |
| **PRESCRIBER’S SIGNATURE:** | | **SELF CARY/ADMINISTER EMERGENCY MEDICATION**  **YES** **NO** | | | | | | | | | | | **DATE** | |
| **PARENT/GUARDIAN SIGNATURE:** | | **SELF CARY/ADMINISTER EMERGENCY MEDICATION**  **YES** **NO** **NOT EMERGENCY** | | | | | | | | | | | **DATE** | |
| **PRESCRIBER’S SIGNATURE:** | | **SELF ADMINISTER PRESCRIBED MEDICATION**  **YES** **NO** **NOT EMERGENCY** | | | | | | | | | | | **DATE:** | |
| **PARENT/GUARDIAN SIGNATURE:** | | **SELF ADMINISTER PRESCRIBED MEDICATION**  **YES** **NO** **NOT EMERGENCY** | | | | | | | | | | | **DATE:** | |
| **PARENT/GAURDIAN SIGNATURE:** | | **PERSON WHO CAN CHECK OUT MEDICATION:** | | | | | | | | | | | **DATE:** | |
| **PARENT/GAURDIAN SIGNATURE:** | | **DISCARD MEDICATION AT THE END OF THE SERSSION.**  **YES** **NO**  **# OF TABLETS/CAPSULES DISCARDED:** | | | | | | | | | | | **DATE:** | |
| **# OF TABLETS/CAPSULES SUBMITTED:** | | **# OF TABLETS/CAPSULES RETUNRED:** | | | | | | | | | | | **DATE:** | |

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