

## Authorization for Self Administration of Medication by Camper

The Bulldog Golf Experience does not dispense any medications to campers. Campers who need to take prescription or over the counter medication must come to camp with authorization of self-administration of medication from both the parents and a physician.

Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and the date of the prescription. All medications must be given to the head camp counselor who will keep them in a locked box in his or her room. Campers must come to the head counselor to access their medications. All unused medication will be destroyed if not picked up within one week following the camper's departure at the end of camp.

### Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Today's Date \_\_\_/\_\_\_/\_\_\_

Medication Name \_\_\_\_\_ Controlled Drug? \_\_\_Yes \_\_\_No

Dosage \_\_\_\_\_ Method \_\_\_\_\_ Time of Administration \_\_\_\_\_

Medication Administration: Start Date \_\_\_/\_\_\_/\_\_\_ Stop Date \_\_\_/\_\_\_/\_\_\_

Relevant Side Effects of Medication \_\_\_\_\_

Plan of Management for Side Effects \_\_\_\_\_

Known Food or Drug: Allergies \_\_\_Yes \_\_\_No Reactions to \_\_\_Yes \_\_\_No

If "yes" to any of the above, please explain \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_

Prescriber's Address \_\_\_\_\_ Town \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_

Authorization for self administration of medication:

I authorize \_\_\_\_\_ to self administer medication. The camper has been taught proper administration of this medication.

Prescriber's Signature \_\_\_\_\_

### Parent/Guardian Authorization for Self Administration of Medication:

I request that my child can self medicate as described and directed above.

Name of Camp \_\_\_\_\_ Today's Date \_\_\_/\_\_\_/\_\_\_

Child's Name \_\_\_\_\_ Address \_\_\_\_\_ Town \_\_\_\_\_

Name of Parent/Guardian Authorizing self administration of medication \_\_\_\_\_

Relationship to Child : Mother \_\_\_ Father \_\_\_ Guardian/Other explain: \_\_\_\_\_

Address \_\_\_\_\_ Town \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Parent/Guardian Authorizing Self Administration of Medication: \_\_\_\_\_

Name of Camp Personnel Receiving Written Authorization and Medication: \_\_\_\_\_

Title/Position \_\_\_\_\_ Signature (in ink) \_\_\_\_\_