AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS

Our Camp infirmary is well stocked with medications most commonly used/needed (as listed on stock medication sheet, other side). If you choose to send a prescription or non-prescription (over the counter) drug to camp with your child, for EACH medication you need to complete this form and have it signed by the prescribing physician.

NO DRUG WILL BE DISPENSED WITHOUT THIS COMPLETED FORM
Please copy this form for each drug you want dispensed Authorized prescriber or dentist's order: Date _____/_____/_____

Name of Child _____Date of birth ___/____/___
Street Address _____City/Town _____ State_____
Condition for which drug is being administrated during camp
_____
DRUG: Name of drug, dose and method of administration
_____
Times of Administration: __,___,___ Medications shall be administered from
__/__/__ - ___/___/___
Relevant side effects to be observed, if any _____
_____
If there are any side effects, plan for management
_____
Is this is a controlled drug? _____
Allergies, reaction to, or negative interaction with food or drugs? If YES, list
_____
The authorized prescriber's or dentist's name _____ Phone ( )
Type or Print
Signature of prescribing physician _____
Address:
Authorization by Parent/Guardian for the administration of the above medication:
Date: _____/___/_____

I hereby request that the above medication, ordered by the authorized doctor/dentist for my child be administered by the nurse or by camp personnel with current Medication Administration Training.

I understand that I must supply **Hidden Valley Equestrian Center, Inc.** CAMP with the prescribed medication in the original container dispended and properly labeled by an authorized prescribed, dentist or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name. Drugs must not have passed the expiration date.

I understand that this medication will be destroyed if it is not picked up within one (1) week following the end of my child's camp stay.

Name of Parent/Guardian _____
Signature of Parent/Guardian_____
Relationship to Child _____ Street Address _____
City/Town _____ State_____ Zip Code_____ Phone

FOR CONTROLLED DRUGS ONLY –TO BE COMPLETED AT CHECK IN Date_____ Number of tablets received: _____ Parent's initials _____ RN initials _____

This section is to be completed by parent/guardian

This infirmary at Hidden Valley Equestrian Center, Inc. Camp stocks the following over-the-counter medication and prescription medications. They are administered by a registered nurse or certified medication administrator. It is not necessary to bring any of these mediations to camp unless your child receives them routinely. Draw a line through and initial any medications you DO NOT want your child to receive.

Aurodri ear drops
Bacitracin
Benadryl Tablets
Benadryl elixir
Benadryl cream/spray _____
Bengay
Calamine
Caladryl
Cloraseptic throat spray _____
Dimetapp
Epipen injection for SEVERE, LIFE-THREATING allergic reaction
Hydrocortisone cream _____
Ibuprofen (Advil or Motrin) _____
Imodium AD
Lotrmin AF
Maalox
Milk of Magnesia
Mylanta
Neural borate rinse _____
Paste of Adolf's meat tenderizer-unseasoned _____
Erythromycin antibiotic eye ointment_____
Rhuligel
Robitussin
Robitussin DM
Sudafed
Tinactin cream
Tobrex eye drops
Tylenol

Medication Authorization

I hereby give permission to Hidden Valley Equestrian Center, Inc. health care personnel to administer any of the above medication (or their generic equivalents) that I have not drawn a line through and initialed per the Standing Orders of the Camp Physician.

Signature of Parents/Guardian_____ Date
(or participant if 19 or over)