2024 CAMP WHIRLYGIG - MEDICATION ADMINISTRATION FORM

CAMPER'S FULL NAME ____

Circle Weeks Attending 7/1 7/8 7/15 7/22 7/29 8/5

This form must be completed and on file at the camp for any prescription or over-the-counter medication that is being brought in from home. All such medications must be kept in the camp health office unless noted below. Please also note that in accordance with 105 CMR 430.160(A) and 105 CMR 430.160(C):

- Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date it was filled, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container.
- All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.
- Medication brought from home will only be administered with the completion of this form with parent/guardian written consent.

Medication Name: ____

Dose: ____

Medication will be given: (choose one)

☐ Scheduled (indicate time) ____

☐ As Needed (describe indications) _____________________________________

All Epinephrine Injectors and inhalers will be kept in the Health Office (Central Campus) unless other arrangements are made with the health supervisor and noted here:

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*Staff members will carry campers' epinephrine injectors and inhalers when going offsite from the museum.

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I give permission for authorized camp personnel to administer the above medication to my child:

Parent/Guardian Signature: ______________________________**Date:**______________

Reviewed and updated: 11/4/2023

Health Office use only.

This instruction was received by the Health Office: _____ In person _____ Camper brought SIGNED completed form

Received in Health Office by ____ Date _________________

Quantity of medication received on date above. (Fluid ounces or Number of tablets) _______________________

Medication Returned to student or family: ________________________________ Date__________________