



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

MEDICATION CONSENT FORM FOR Y-CAMPS

1. Child's First and Last Name:	2. Date of Birth:	3. Child's Known Allergies:
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MEDICATION INFORMATION

4. Name of Medication (including strength):	5. Amount/Dosage to be given:	6. Route of Administration:
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7A. Frequency to be Administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication:
(signs & symptoms must be observable and when possible, measurable parameters)

8A. Possible Side Effects: See package insert for complete list of possible side effects (parent must supply)

AND/OR

8B. Additional Side Effects: _____

9. What action should the camp take if side effects are noted:

Contact Parent Contact prescriber at phone number provided below

Other (describe): _____

10A. Special Instructions: See package insert for complete list of special instructions (parent must supply)

AND/OR

10B. Additional Special Instructions: (include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.)

11. Reason the child is taking medication (unless confidential by law): _____

DOUBLE SIDED FORM



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PRESCRIBER INFORMATION

12. Date Prescriber Authorized:	13. Prescriber's Telephone Number:
14. Prescriber's Name (Please Print):	
15. Licensed Authorizes Prescriber's Signature:	

PARENT INFORMATION

16. Date Parent or Legal Guardian Authorized:	17. Parent/Legal Guardian's Telephone Number:
18. I, parent/legal guardian, authorize the camp to witness the self-administration of the medication as specified in the medication information section to _____ (Child's Name)	
19. Parent or Legal Guardian's Name (Please Print):	
20. Parent or Legal Guardian's Signature:	

CAMP INFORMATION

21. Camp Name:	22. Camp Telephone Number:
23. I, have verified that #1-#20 are complete. My signature indicates that all information needed to witness the self-administration of this medication has been given to the camp: _____	
24. Camp Director or Health Director's Name (Please Print):	25. Date Received from Parent:
26. Camp Director or Health Director's Signature:	
27. Date Parent/Guardian notified to Pick Up Medication: _____ Staff Signature: _____	
Date Picked Up by Parent: _____ Date Discarded: _____	

DOUBLE SIDED FORM