Town of Matthews Parks, Recreation & Cultural Resource

# Health/Medication Form

This form must be completed fully. A new health/medication form must be completed at the beginning of each camp season, for each medication, and each time there is a change in dosage or distribution of medicine.

I. GENERAL INFORMATION

Site name/program: Camp FUNshine 2018

Participant Name:

II. MEDICATION – PRESCRIBER'S AUTHORIZATION
Name of Medication (includes emergency medical devices):
Reason for medication(s):
Emergency Medication: YES (see section IV) NO
Medication Dose/Frequency:
If PRN, what symptoms?
Possible side effects of medication(s):
Physician Name & Title (printed):
Physician address:

III. PARENT/GUARDIAN AUTHORIZATION
____ _____ I request the authorized youth camp operator/staff to supervise the camper in self-administration if authorized 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 distribution of medication at the facility. I understand that at the end of the authorized period, an adult must pick up the medication, otherwise it will be discarded within ONE WEEK of the camper leaving camp. I authorize camp personnel to communicate with the prescriber as allowed by HIPPAA. I agree to release the M-NCPPC and its agents from any and all liability arising as a result of this waiver. Printed Name (Parent/Guardian) Signature (Parent/Guardian) Date

IV. AUTHORIZATION FOR SELF-CARRY
This section should only be completed if this medication is approved for self-administration. Self-carry is only permitted for emergency medical devices such as inhalers or epinephrine. Both the prescriber and the parent/guardian must consent to self-administration by signing below, however camp operators are not required to permit self-administration or 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. If indicated below, the child named above may self-carry emergency medication. I agree to release the Town of Matthews Parks, Recreation and Cultural Resource Department and its agents from any and all liability arising as a result of this waiver.
Prescriber's Signature:_____
Self-Carry Do NOT Self-Carry N/A (non-emergency)
Parent/Guardian's Signature:_____
Self-Carry Do NOT Self-Carry N/A (non-emergency)

V. ALLERGY/OTHER INFORMATION
Does the individual have any allergies staff should be aware of?
None Food Medication Environmental (pollen, poison ivy, etc.)

Describe Allergy:_____
Reaction Level: ___ Mild ___ Moderate ___ Severe
Required Treatment:
_____
_____
Are there any health concerns staff should be aware of? No Yes Please Explain:
Are there any physical, psychiatric, behavioral, emotional, or developmental concerns staff should be aware of? No Yes Please Explain:
Date of Last Seizure (if applicable):_____