Camp Kahok
Authorization for Administration of Medication Form

COMPLETE THIS FORM ONLY IF YOUR CHILD NEEDS MEDICATION ADMINISTERED WHILE ATTENDING CITY OF COLLINSVILLE PARKS AND RECREATION SUMMER CAMP

INSTRUCTIONS

All medication should be taken by children at home whenever possible.

If it is necessary for a child to take a prescribed medication during program hours, this form must be completed in full by the physician and signed by the parent or guardian, giving specific instructions.

The City of Collinsville will not knowingly allow a child to take prescription or over-the-counter medication during program hours without the parents and physicians authorization. After the City of Collinsville receives the appropriate authorizations, the assigned Lead Camp Counselor will store the medication in a secured area that is accessible only to authorized personnel. Exceptions will be made if permission is given by the child's parent and physician for the child to carry the medication during program hours, certifying that he/she can safely self-administer the dosage.

- Parents/guardians are expected to hand-deliver medication to the Lead Camp Counselor unless the child is authorized by the parent and physician to carry the medication.
- Collinsville Parks & Recreation cannot guarantee refrigeration for medication at the program sites. The Collinsville Activity Center has refrigeration accessible for such medications but limited availability.
- No over-the-counter drugs will be administered unless prescribed by a physician. (i.e., Tylenol, Benadryl, cough medicines).
- All medications must be brought to the program in the original pharmaceutical container and labeled with the child's name, medication dosage, and schedule.
- Parents/guardians should not provide more medication than is necessary for the current day.
- All measuring utensils used for administering medications must be labeled with the child's name on the utensil and brought in with the medication.
- Pills will not be broken in half by the camp staff. All half dosages need to be split prior to the program.
- Parent/guardian must submit a new authorization whenever there is a change in the dosage or medication, or a change in the conditions under which the child is to take the medication.

PARTICIPANT'S NAME: _____ AGE: _____ D.O.B. _____

I/We the undersigned request that medicine be administered or self-administered to the above child by a designated member of the Recreation Staff/ or by the child in accordance with the instructions outlined above and signed by our physician. It is to be given at the time, proper dosage, and route of administration per the physician's instructions outlined above. I voluntary agree to release, discharge, and hold harmless the City of Collinsville and its officers, agents, and employees for any and all claims of liability arising out of their negligence, recklessness or any other act of omission which causes our child's illness, injury, death and damages of any nature in any way connected with the administration of our child's medication. I understand the major responsibility for a child taking medication rests with the child and his/her parents/guardian, and we are required to personally bring the medication to the camp.

Parent/Guardian Name: _____ Phone Number: _____

Parent/Guardian Signature: _____ Date: _____

Physician Instructions:

Please Note: medical personnel are not available during the camp. Whenever possible, please prescribe medication that can be given outside of the summer camp hours (7:00am – 6:00pm).

If medication must be administered during the camp hours, please complete the information below.

MEDICATION	DOSAGE	ROUTE OF ADMINISTRATION	TIME OF DAY

Diagnosis or indication for medication:

_____

Length of time to be taken:

_____

Precautions, if any:

_____

a) For emergency medication, is the child capable of self-administering the necessary treatment/medication?

Yes___ No____

b) Will the child need to carry this medication on his/her person?

Yes____ No____

c) Will the child need to self-administer this medication?

Yes____ No____

Please note the obvious side effects of this particular medication:

_____

_____

PHYSICIAN INFORMATION

Name: _____ Phone: _____

Physician's Signature: _____ Date: _____