Prescription Medication Administration Form For Express C.A.M.P.

The parent/guardian of ___________________ requests that the Express C.A.M.P. staff member, Emily Knuth, administer the following prescription medication ____________________ during camp hours according to the Parent/Guardian's signed instructions below.

Emily Knuth agrees to administer prescription medication prescribed by a licensed health care provider only. It is the parent’s/guardian’s responsibility to furnish the medication. The parent/guardian agrees to pick up any unused medication and the prescription bottle on the last day of camp, July 14, 2023. Any medication left after 3 PM on July 14, 2023, will be properly disposed.

**Prescription medications must be provided to Emily Knuth in a pharmacy-labeled container with clear dosage instructions on the first day of camp.**

By signing this document, I give permission for my child’s health care provider to share information about the administration of this medication with Emily Knuth, the delegate to administer medication, should clarification be needed.

____________________  ____________________  ____________
Parent/Guardian Printed Name  Parent/Guardian Signature  Date

____________________  ____________________
Daytime Phone #  Cell Phone #

**Complete one form for each medication**

____________________  ____________________  ____________________
Name of Prescription Medication  Dosage  Time to administer medication

____________________
Medication Start Date

____________________
Medication End Date

____________________  ____________________
Name of Prescribing Provider  Provider’s Phone Number

____________________
Special instructions or side effects to know

**Please ask the pharmacist for a separate medicine bottle with a label to keep at camp**
Authorization to Self-Carry/Administration of Metered Dose Inhaler Release Form

Student____________________________ DOB ____________

Medication Dose __________ Time________

Method of Administration Metered Dose Inhaler Spacer (Y/N) ________

Diagnosis__________________________ Other ___________________________

Possible Side Effects/Precautions/Recommended Interventions:
____________________________________________________________________

Duration (dates) of Administration: From July 11, 2022 to July 15, 2022

I request that my child be allowed to carry/self-administer his/her Metered Dose Inhaler medication and be responsible for its proper storage and use. I take responsibility for this permission. I understand that this medication must be in the original pharmacy container, labeled with name of student. I will support my child to follow the above agreement and if s/he does not, I will be contacted and we will develop a new plan.

By signing this document, I give permission for my child’s health care provider to share information about the administration of this medication with the nurse delegated to administer medication should clarification be needed.

____________________________________________________________________

Parent/Guardian Signature __________ Date __________ Daytime Telephone Number __________

I have demonstrated the correct use/administration of this medication and agree to terms of this contract. I will keep medication in agreed location, will not share this medication with others, and will seek assistance from Emily Knuth if I have have the following symptoms after using the medication:

____________________________________________________________________

Student Signature ___________________ Date __________

____________________________________________________________________

Name of Prescribing Provider ___________________ Provider’s Phone Number ___________________
Authorization to Self-Carry/Administration of EpiPen Release Form

Student_____________________________ DOB ______________

Medication Dose ___________ Time ___________

Possible Side Effects/Precautions/Recommended Interventions:

____________________________________________________________________________________________

Duration (dates) of Administration: From July 11, 2022 to July 15, 2022

I request that my child be allowed to carry/self-administer their EpiPen and be responsible for its proper storage and use. I take responsibility for this permission. I understand that this medication must be in the original pharmacy container, labeled with name of student. I will support my child to follow the above agreement and if they do not, I will be contacted and we will develop a new plan.

I hereby authorize the Prindle Institute for Ethics, and its agents and representatives, to administer to the camper an epinephrine injection if they are experiencing an allergic reaction and are unable to inject themselves. I understand that epinephrine may be administered by any trained staff member; however, said staff member may not be a licensed medical professional. I also understand that camp staff will contact emergency medical services and the parent or individual listed as emergency contact for the camper whenever epinephrine is administered, regardless of whether the camper continues to exhibit symptoms of anaphylaxis. I hereby agree to indemnify, release, and hold harmless DePauw University, the Prindle Institute for Ethics, its directors, officers, agents, employees, and staff, from any claim, demand or action regarding the administration of epinephrine.

By signing this document, I give permission for my child’s health care provider to share information about the administration of this medication with the nurse delegated to administer medication should clarification be needed.

__________________________________________ ____________________________ ____________________________
Parent/Guardian Signature Date Daytime Telephone Number

I have demonstrated the correct use/administration of this medication and agree to terms of this contract. I will keep medication in agreed location, will not share this medication with others, and will seek assistance from the camp nurse if I have have the following symptoms after using the medication:

__________________________________________ ____________________________
Student Signature Date

__________________________________________ ____________________________
Name of Prescribing Provider Provider’s Phone Number