# Cal Youth & Outdoor Programs Medication Form

Return completed form to your camp office or the Enrollment Center
Phone: (510) 643-CAMP (2267) FAX: (510) 642-8343 E-mail: scrainfo@berkeley.edu

**CAMPER'S** Name _____ Camper's Age _____
(Last) (First)

Camp/Program(s) & Dates (e.g. Explorer, Blue, Cal Adventures, Skateboard, S2) _____

_____

**FORM MUST BE COMPLETED BEFORE ANY MEDICATION IS BROUGHT TO CAMP**

**This form must be completed and signed for prescribed and non-prescribed medications by the parent/guardian, and for prescribed medications, by a physician, before any medication can be administered at camp.** All medications, whether prescribed or non-prescribed, are kept in the camp office. **If you would like your child to carry either an asthma inhaler or other emergency medication (i.e. Epipen or Glucagon), form must be completed and signed by the camper's legal guardian. ***** The parent or adult representative must **bring all medications to camp in their original container *****

******DO NOT SEND MEDICATIONS WITH YOUR CHILD.******

**PART 1: PARENT/GUARDIAN:** Both prescribed and non-prescribed medications will be administered by authorized camp personnel in the manner and dosage given. By signing below I hereby request that authorized personnel assist this camper in taking the medication in the manner and dosage given. ***I understand all medications must be in their original container.***

**PERMISSION TO CARRY ASTHMA INHALERS/EPIPENS**

The above-named camper has been instructed in the proper use of their asthma inhaler/emergency medication. The child's well-being is in jeopardy unless this medication is carried on his/her person. Therefore, I request that he/she be permitted to carry the asthma inhaler/emergency medication at camp. He/she understands the purpose, appropriate method, and frequency of use of asthma inhaler/emergency medication.

**PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS (OTC)**

I (Parent/Guardian) hereby give permission for Cal Youth & Outdoor Programs, to administer to my child, the following over-the-counter medications (or their Generic Equivalents) if the camp medical personnel deems it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise. It is the intent of program staff to encourage and use, non-drug therapies before recommending or administering pharmaceuticals.

**Permission is granted to administer the following OTC medications:** ❑ **No** ❑ **Yes** If yes, please ✓ check all that apply.

❑ Tylenol® (Headache) ❑ Pepto Bismol® or other Ant-Acid (Upset Stomach) ❑ Benadryl (Allergic Reactions)

**Name of Medication** _____ **Form** _____ **Dose** _____
(liquid, tabs, inhaler, etc.)

**Schedule of Doses** (When) _____ **Date to Stop Medication** _____

**Restrictions, Cautions, Side Effects** _____

**X** _____
**Parent/Guardian Signature** Printed Name/Relationship

(_____)_____ (_____)_____
Main contact phone Alternate contact phone

**PART 2: PHYSICIAN: Confirm above medication information** (Signature not needed if **non**-prescription medication)

**X** _____
**Physician Signature** Printed Name Date

Physician Phone # (_____) _____ Address_____

**PART 3: CAMP DIRECTOR** (to be completed by Camp Director or designated camp medical staff)

_____
Person(s) designated by camp director to assist camper in taking medication above

**X** _____
Signature of Camp Director or designated camp medical staff Date