UNIVERSITY of INDIANAPOLIS

Medication Prescriber/ Parent Authorization

CAMP/ PROGRAM INFORMATION

Camp/program _____

Date(s) _____ Time(s) _____

PARTICIPANT'S INFORMATION

Participant's Parent/ Legal Guardian (if applicable) _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth ____/____/____ Gender: M/F

☐ No, my child does not need to take any medication while at camp/ during program/ trip

☐ Yes, my child will need to take medication while at camp/ during program/ trip (check one):

☐ Prescription Medication ☐ Over-the-Counter Medication

This form must be completed fully in order for participants to administer required medication to themselves. A new medication administration form must be completed for each camp/ program attended by the participant, and each time there is a change in dosage or time of administration of a medication. This authorization requires a licensed health care authorization and signature, and parent signature.

- Prescription medication must be in its original container labeled by a pharmacist or prescriber. Label must include the name, address and phone number for the pharmacist or prescriber.
- Containers must hold only the amount required for the time the participant will be attending the camp/ program.
- All prescription medications, including medications for conditions such as food, drug or insect allergies; diabetes; asthma; or epilepsy may be brought under the condition that the participant can self- manage care and delivery of medication with written authorization to do so at camp by a licensed health care provider.

PRESCRIBER AUTHORIZATION FOR SELF-ADMINISTRATION FOR PRESCRIPTION MEDICATION

Medication _____ Dose _____

Condition for which medication is being administered _____

_____

Specific Directions (e.g. on empty stomach/ with food etc.)_____

_____

Time/ frequency of administration _____

If PRN, frequency _____

If PRN, for what symptoms _____

Relevant side effects _____

Medication shall be administered from __/__/__ to __/__/__

Special Storage Requirements _____

Is the participant capable of self- managed care? ○ Yes/ ○ No

Prescriber's Name/ Title _____

Prescriber's Place of Employment _____

Telephone _____ Fax _____

I hereby affirm that this individual has been instructed in the proper self - administration of the prescribed medication (s).

Prescriber's Signature _____ Date _____

PARENT/ GUARDIAN AUTHORIZATION, WAIVER AND CONSENT FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

I authorize and recommend self- medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the University of Indianapolis against any claims that may arise relating to my child's self-administration of prescribed medication(s).

I/ We have legal authority to consent to medical treatment for the participant named above, including the administration of medication at the above referenced camp/ program.

Parent/Guardian Signature _____ Date _____

Home Phone _____ Cell Phone _____ Work Phone _____

PARENT/ GUARDIAN AUTHORIZATION, WAIVER AND CONSENT FOR OVER THE COUNTER MEDICATION

Over-the-Counter (OTC) Medication may at times need to be administered, if approval is indicated by the participant's parent or guardian. Please complete the following section to save time if your child needs any of these OTC medications during his/ her stay.

Note: Unless we have parental authorization, we cannot administer ANY medications.

I hereby authorize that the following medications may be given to _____(name) if the need arises. You may only dispense those that are checked.

- o Ointments for minor wound care, first aid as directed. (Antiseptic, anti -itch, anti- sting, antibiotic, sunburn.)
- o Tylenol/ Acetaminophen as directed
- o Aspirin/ Ibuprofen as directed
- o Throat lozenges and or spray as directed for sore throat.
- o Micatin or anti-fungus treatment as directed for athlete's foot
- o Kaopectate or lmodium for diarrhea as directed
- o Milk of Magnesia, Pepto Bismol or Mylanta for upset stomach or nausea as directed
- o Rola ids or Tums for acid reflux, heartburn or indigestion as directed
- o Benadryl for swelling, hives, allergic reaction as directed
- o Actifed or Sudafed as directed for nasal congestion or allergy relief per instruction.
- o Visine or other eye drops for minor eye irritation
- o Medicated lip ointment for dry, chapped lips, lip blisters or canker sores
- o Swimmer's ear drops as directed
- o Hydrocortisone ointment as directed for mild skin irritations, poison ivy and insect bites
- o Medicated powder for skin irritation as directed
- o Calamine lotion for bug bites and poison ivy
- o Sunscreen
- o Bug repellent
- o Other (list any approved over the counter drugs*)

_____

_____

_____

_____

CAMP STAFF RESERVES THE RIGHT TO USE GENERIC EQUIVALENTS WHEN AVAILABLE FOR THE NAME BRAND OVER-THE-COUNTER MEDICATIONS LISTED ABOVE.

I understand that such administration will not be done under the supervision of medical personnel. I also agree that any first aid treatment may be given as needed.

Any condition which is associated with a fever, significant inflammation and/ or did not respond to the above outlined treatment, will be followed up with a consultation with the participant's parents. Parent/ guardian will be contacted if any conditions develop requiring treatment with any of the above over the counter medication that are not checked.

I understand that these over the counter medications are not necessarily kept on hand and available to be administered immediately.

I authorize the administration of the over the counter medication to my child as indicated above.. I shall indemnify and hold harmless the University of Indianapolis against any claims that may arise relating to my child being administered the above indicated over the counter medications.

I/We have legal authority to consent to medical treatment for the participant named above, including the administration of medication at the above referenced camp/program.

Parent/Guardian Signature _____ Date _____

Home Phone _____ Cell Phone _____ Work Phone _____