Yellowstone Adventure Camp Medicine Administration Authorization

Prescriber's Authorization (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse)

Only one medication per form, please.

Participant Name _____ Date of Birth ____/____/____ Today's Date ____/____/____

Medication Name _____ Emergency Medication? ☐ yes ☐ no

Dosage _____ Method _____ Time of Administration/Frequency_____

Specific Instructions for Medication Administration (e.g., on empty stomach, with milk, etc.) _____

_____ Specify Precautions _____

Medication Administration: Start Date ____/____/____ Stop Date ____/____/____ Quantity Received _____

Expiration Date of Medications Received ____/____/____ Special Storage Requirements _____

Relevant Side Effects/Adverse Reactions _____

Plan of Management for Side Effects _____

Known Food or Drug: Allergies? ☐ yes ☐ no Reactions to? ☐ yes ☐ no Interactions with? ☐ yes ☐ no

If "yes" to any of the above, please explain _____

Diagnosis (at parents discretion) _____

Prescriber's Name _____ Business Telephone _____

Prescriber's Signature _____ Prescriber's Emergency Telephone_____

Prescriber's Address _____ Town/State/Zip _____

Parent/Guardian Authorization

I request the authorized youth camp operator/staff to administer the medication or 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 administration 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. I authorize camp personnel to communicate with the prescriber as allowed by HIPAA.

Name of Parent/Guardian Authorizing Administration of Medication _____

Relationship to Child: ☐ Mother ☐ Father ☐ Guardian/Other (explain): _____

Signature of Parent/Guardian _____ Date ____/____/____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Authorization for Self Administration/Self Carry

This section should only be completed if this medication is approved for self administration. Self carry is only permitted for emergency medications such as inhalers, insulin and epinephrine. Both the prescriber and the parent/guardian must consent to self administration below. However, youth 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.

Prescriber's Signature	Self Carry Emergency Medication (check one) ☐ yes ☐ no ☐ n/a (not emergency medication)	Date
Parent's Signature	Self Carry Emergency Medication (check one) ☐ yes ☐ no ☐ n/a (not emergency medication)	Date

Name of Camp Staff Receiving Written Authorization and Medication _____

Title/Position _____ Signature _____