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Medication Protocol:
All medications (both over-the-counter and prescribed) must be cleared by the camper's guardian (additionally all prescribed meds must be cleared by a Physician) by filling out the appropriate documented forms: Over-the-Counter Medication Permission Form and/or Prescription Medication Form. Additionally, all camper guardians–must fill out the Nature Adventure's Release Form .

Over-the-Counter Medications:
Parents/Guardians must fill out the "Over-the-Counter" medication permission form, specifying what over-the-counter item they would like their child to take. This would include things like antacids, aspirin and topical treatments (such as Technu). Please indicate if the camper can self-administer the specified medication or if a responsible staff member (over 18) must administer the specified over-the-counter medication.
Campers cleared to self-administer are expected to be responsible for their over-the-counter item at all times, and it is suggested that they carry it in a backpack. The guardian ***must*** provide the over-the-counter medication in a clearly marked zip loc bag (and in original packaging) with the child's name and session. Over-the-counters may not be administered if the "Over-the-Counter Medication Permission" form has not been filled out and turned in.

Prescribed medications (from a medical professional):
Prescribed medications includes epi-pens, inhalers, & antibiotics. The Prescription Medication Permission form must be filled out and signed by a Physician and the release waiver must also be filled out by the guardian. All meds should be provided in original packaging and with a labeled zip loc bag that indicates the camper's name and camp session. If a camper is explicitly cleared to carry an epi-pen, inhaler or prescribed medicine on their person they must have it at all times. It is recommended that the student carries this in something like a back-pack. If your child is not capable of handling or administering their prescribed medication please inform the Camp Director (Ty Chin) as soon as possible.

Please email: tchin@sbnature2.org for more details.

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Prescription Medication Permission Form

(Authorization to Administer/Dispense Prescription Medications by SBMNH Youth Camp Personnel)

□ Prescription Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber's name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name (**See separate form**).

(**This Section MUST be SIGNED by a legally authorized prescriber (e.g. Physician or Dentist**))

AUTHORIZED PRESCRIBER'S ORDER: Date ____/____/_____
Name of Child
_____

Date of Birth____/____/____

Street Address_____

City/Town _____State ____

Condition for which drug is being administered during camp hours
_____

DRUG: Name of Drug, Dose and Method of Administration
_____

Times of Administration: ____, _____, ____ Medication shall be administered from ____/____/____-____/____/____

Relevant side effects to be observed, (if any):

_____

_____

_____

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If there are side effects to medication(s), what is the plan for management?:

_____

_____

_____

Is this a controlled drug?

_____

_____

_____

Allergies: Reaction to, or negative interaction with food or drugs? If YES, list :

_____

_____

_____

The legally authorized Prescriber's Name

_____
(Print Name Clearly)

Phone # (_____) _____

Street Address_____

City/Town_____ State ___

Authorized Prescriber:

Signature_____

(Parent or Guardian, please complete Parent/Guardian Authorization as well)

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Parent/Guardian Authorization for Prescribed Medications

Authorization by Parent/Guardian for the administration of the above medication: Date: ____/____/____

(Parent or Guardian's Signature Required)
I hereby agree that the above medication, ordered by the legally authorized prescriber: (M.D., P.A., APRN) for my child_____, may be dispensed by camp personnel.

I understand that I must supply the SBMNH Youth Camp with the prescribed medication in the original container, dispensed and properly labeled by a legally authorized prescriber. Over the counter medication shall be in the original container, labeled by the parent/guardian with the child's name (use separate Nonprescription Medication Permission form). If administered by SBMNH Youth Camp personnel, I understand that the person giving the medication may not be medically trained. I agree to inform the SBMNH immediately of any changes relating to the medication or other medical information, including changes in when or if the medication is taken or any reaction to the medication. I agree that when the medication(s) is/are discontinued, or upon completion of the camp, I will pick up all unused medication. Unclaimed medications may be discarded or destroyed.

Name of Parent or Guardian _____(Print Name Clearly)

Signature _____

Relationship to child _____

Address_____

City/Town_____ State_____

Zip Code_____ Phone (_____) _____

(Authorization to Dispense Nonprescription Medications is a Separate Form – See Attached)

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Over the Counter (O.T.C.) Medication Permission Form

Date received by SBMNH Camp:_____

MEDICATION MUST BE BROUGHT IN THE ORIGINAL CONTAINER

Child: _____ Date of birth (age): _____

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Reason for medication:
_____

Name of medication:
_____

Form of medication/treatment: ___ Tablet/Capsule ____ Injection ____ Liquid
_____Inhaler ____ Other_____

Instruction: (list specific times dosage should be given): _____

Start date: _____ Stop date: _____

_____ For episodic/emergency events only

RESTRICTIONS and/or important side effects:
_____ NONE anticipated

___Yes Write clearly on the reverse side of this form any specific restrictions or side effects.

Special requirements: _____ None _____Refrigerate _____Other:_____

Physician Name:
_____
Address:
_____
Phone:
_____

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TO BE COMPLETED BY PARENT/GUARDIAN:

I give permission for (name of child) _____ to receive the above medication at the SBMNH camp. I understand that the person giving the medication may not be medically trained. I agree to inform the SBMNH immediately of any changes relating to the medication or other medical information, including changes in when or if the medication is taken or any reaction to the medication. When medication is discontinued, or upon completion of the camp, I will pick up all unused medication. Unclaimed medications may be discarded or destroyed.

Date: _____ Signature: _____