CAMP SHADY BROOK

YMCA OF THE PIKES PEAK REGION

PERMISSION FOR MEDICATION AT CAMP SHADY BROOK

NOTE: This form is NOT required for families who intend to authorize the CSB Medical Team to administer medications that are stocked in the Medical Center on an "as needed" basis.

The parent/guardian of_____ ask that Camp Shady Brook staff give the
Camper's Name
following medication to my camper, according to the Health Care Provider's signed instructions on the lower part of this form.
Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, route, date medicine is to be stopped, and licensed Health Care Provider's name. Pharmacy name and phone number must also be included on the label.

The camp agrees to administer medication prescribed by a licensed Health Care Provider with prescriptive authority. The parent agrees to pick up expired or unused medication within one week of notification by staff. All medication(s) left at Camp Shady Brook will be discarded according to the most current state regulatory recommendations for safe medication disposal.

Over The Counter Medications: This form is required if you will be sending campers with over the counter medications and/or would like to give permission for Camp Shady Brook's Medical Staff to administer over the counter medications on a regular basis (ex. Claritin every day at 8:00 a.m.). OTC medications also must be kept in original packaging, please ensure they are not expired.

By signing this document, I give permission for my child's Health Care Provider to share information about the administration of this medication with Camp Shady Brook staff delegated to administer medication.

Parent/Legal Guardian's Name	Parent/Legal Guardian Signature	Date

Health Care Provider Authorization

Medication_____ Dosage _____ Route_____
Special Instructions _____
Purpose of Medication _____
Side Effects to be reported _____

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Special Instructions _____
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Sessions camper is in attendance ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

Signature of Health Care Provider with Prescriptive Authority	Date
Print Name of Health Care Provider	Phone & Fax Number
Signature of Child Care Health Consultant or School Nurse	Date

Colorado's Medication Administration Training for Unlicensed Assistive Personnel in Public, Charter, Private and Parochial Schools, Child Care Centers, Preschools, School-Age Child Care, Residential Camps, Day Camps, and Family Child Care Homes, 9/2017, Sixth Edition