Massachusetts Junior Conservation Camp

Mailing: PO Box 306 - Northborough, MA 01532
Phone: 508-450-5120 Email: MAJuniorCamp@gmail.com
Website: www.juniorconservationcamp.org

ADMINISTRATION OF MEDICATION

Camper's Name	Age	Sex

The Camp has a responsibility to its staff and will not, by policy or administrative regulation, permit them to perform duties which could jeopardize or infringe their rights under law. This policy for the administration of medication at Camp is designed to protect the health of the child and to protect the staff.

- *All medication (prescription and non prescription) must be kept in the Health Supervisor's office and administered only as indicated.*
- *Medications shall be administered only by the Health Supervisor or his/her designee.*
- *An Administration of Medication form must be completed for each camper, and kept on file by the Health Supervisor.*
- *Administration of Medication forms must be properly filled out, detailing all prescribed medications.*
- *For non-prescription medication, a written parental request must be submitted stating the type of medication and the frequency with which it is to be administered.*
- *The Health Supervisor shall have the right, with just and reasonable cause, to refuse the administration of medication.*
- *No self administration of medication will be permitted, with the sole exception of inhalers, EPI-pens, and diabetic medication if so directed by the camper's physician.*
- *All prescription medication must be brought to and from camp by a parent or other adult.*
- *All medication must be properly labeled with only the name of the camper to whom it will be given. Use the original container whenever possible.*
- *It is not necessary for parents to provide over the counter medications such as Tylenol, Advil, Motrin, etc., as the Health Supervisor will have a supply.*

PARENTAL PERMISSION

I hereby give permission for my child to be given medication as prescribed and directed by our physician (or as directed by me, if non-prescription medication).

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Signature of Parent or Guardian Date

PHYSICIAN'S ORDER FOR CAMP NURSE

The physician may attach written orders instead of filling out this section.

Drug	Prescription #
Dosage/Frequency	Duration
Diagnosis	

Drug	Prescription #
Dosage/Frequency	Duration
Diagnosis	

Physician's Name _____Date _____

Physician's Signature_____

Address _____ Phone _____