Medicine Reminder

Please print and send to parents

- Medicines at Camp McDowell are subject to the same rules as medicines brought to school for administration by the school nurse
- Scheduled medicine times are: Before Breakfast, After Breakfast, After Lunch, Canteen (4pm), After Dinner and Night Snack (8:30pm)
- Prescription medicines **MUST** be in their original containers and have a label containing:
    - Student Name
    - Name of Prescription Drug
    - Strength of Prescription Drug
    - Administration directions ("give as directed" is **NOT** acceptable)
    - Parents must indicate what time medication is to be taken
    - Please only send the exact amount needed of prescription medications
- Parents/Guardians **must provide any over-the-counter medicines** they anticipate their child may need. OTCs must be in the original, unopened, and sealed container.
    - If your child is under 12, send a children's version of OTC medications. If they require a dose above the recommended children's dosage, a doctor's note or prescription will be required.

➔ If your child requires an Epi-Pen, inhaler, or other **rescue medication** be kept around them at all times while at Camp, please have a provider fill out the **Rescue Mediation Authorization Form** below

If you have any additional questions about medication, please contact
Camp McDowell Farm Nurse *at 205-387-1806 ext. 119 or farmnurse@campmcdowell.org*

Medication Packing Sheet

Please print and pack with medication

Please place this sheet in a ziplock bag with your child's medicine. All information must be completed by a parent or legal guardian. Please fill out the information for prescription and over the counter medicines.

Student's Name:_____ School:_____

PRESCRIPTION MEDICATIONS: Circle the time(s) to administer the medicine to the child, choose from following:
B*= Before Breakfast, **B**= After Breakfast, **L**= After Lunch, **C**=Canteen (4PM), **D**= After Dinner, **HS**= At Bedtime
**If a time is not selected, medicines will be given after breakfast.*

Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS**
Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS**
Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS**

OVER THE COUNTER (OTC) MEDICATIONS: All OTC Medications **MUST** be provided by parents/legal guardians and in original, unopened, and sealed containers. Circle "As Needed Only", if medication is not taken daily.

Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS** **As Needed Only**
Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS** **As Needed Only**
Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS** **As Needed Only**

Rescue Medication Authorization

*****MUST BE FILLED OUT BY A LICENSED HEALTHCARE PROVIDER*****

Please fill out this form if your child requires rescue medication to be with them ***at all times***.
All rescue medications (i.e. EpiPens, inhalers, etc.) will be kept around the student at all times in case of an emergency while away from the health hut or Nurse.

STUDENT INFORMATION

Student's Name:_____ School:_____

Date of Birth: _____

PRESCRIBER AUTHORIZATION *(To be completed by licensed healthcare provider)*

Medication Name:_____ Dosage:_____ Route: _____

Frequency/Time(s) to be given:_____

Start Date: _____ Stop Date: _____

Reason for taking medication: _____

Potential side effects/contraindications/adverse reactions:

_____

Treatment order in the event of adverse reaction: _____

SPECIAL INSTRUCTIONS *(To be completed by licensed healthcare provider)*

Is self-medication permitted? ☐ **Yes** ☐ **No**

- If "yes" I hereby affirm this student has been instructed on the proper self-administration of the prescribed medication

Do you recommend this medication be kept "on person" by the student? ☐ **Yes** ☐ **No**

- If "no" I hereby affirm that a school personnel, chaperone, or authorized Camp McDowell staff member is allowed to carry the medication around the student while at Camp (ensuring students have rescue medication while hiking or when too far away from the nurse's office)

Printed Name of Licensed Healthcare Provider: _____

Provider Office Phone #: ( ) _____ - _____ Fax: ( )_____ - _____

Signature of Licensed Healthcare Provider:_____ Date: _____

SELF-ADMINISTRATION AUTHORIZATION

To be completed ONLY if student is authorized for complete self-care by a licensed healthcare provider

I authorize self-medication by my child for the above medication. I also affirm that they have been instructed in proper self-administration of the prescribed medication by their attending physician. I agree that Camp McDowell will not be responsible for any adverse effects, illness, or injury caused by the self administration of the prescribed medication(s). ***If you give permission to self-administer, please sign below:***

Parent's/Legal Guardian's Signature: _____ Date: _____