Confidential Prescription Medication Form

This form is to be completed by a physician, nurse practitioner or dentist only if your camper needs prescription medication administered at camp. Please return this form by email (SSFS.Camp@ssfs.org), fax (301-830-6847), or postal mail (Camp Office, 16923 Norwood Road, Sandy Spring, MD 20860.)

Medication is to be brought to the camp nurse by parents or guardians. Medication must be in the original container and clearly marked. Unclaimed medication will be destroyed at the end of camp.
Please use one sheet per medication

Camper's Name: _____ DOB: _____

Name of Medication: _____ Reason for Medication: _____

Dose: _____ Route: _____ Time: _____ Effective Dates: _____

☐ Checking this box indicates that the medication is an epi-pen or inhaler that the camper can carry and self-administer

Possible adverse effects: _____

Any drug interactions: _____

Additional instructions: _____

Allergies: _____

Physician's/Prescriber's Signature: _____ Date: _____

Name of Physician: _____ Physician's phone #: _____

(Print)

I release the camp and its personnel of any liability related to the administration of the above listed medication. I give permission to the camp personnel to communicate directly with the prescribing physician.

Parents/Guardian's Signature: _____ **Date:** _____

FOR CAMP USE ONLY

	17	18	19	20	21		24	25	26	27	28		1	2	3	X	5
June/July																	
	8	9	10	11	12		15	16	17	18	19		22	23	24	25	26
July/Aug																	
	29	30	31	1	2		5	6	7	8	9						
Jul/Aug																	

Name/Position	Initials

Codes (use for unusual situations)

F – Med given on field trip
A – Absent
R – Refused
N – None available
S – Self-administered
H – Medication held
ED – Early dismissal
O – Omitted
D/C – Discontinued