



# 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

	29	30	1	2	X		6	7	8	9	10		13	14	15	16	17
June/July																	
	20	21	22	23	24		27	28	29	30	31		3	4	5	6	7
July/Aug																	
	10	11	12	13	14												
Jul/Aug																	

Name/Position  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Initials  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Codes (use for unusual situations)	
F - Med given on field trip	H - Medication held
A - Absent	ED - Early dismissal
R - Refused	O - Omitted
N - None available	D/C - Discontinued
S - Self-administered	