

Gretna Glen Camp & Retreat Center
 EASTERN PENNSYLVANIA CONFERENCE OF THE UNITED METHODIST CHURCH
 Any questions, please call: 717-273-6525
AUTHORIZATION FOR MEDICATION ADMINISTRATION

PLEASE NOTE: **ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS MUST BE AUTHORIZED BY A PHYSICIAN/PROVIDER.** You may copy this form.

Child's Full Name _____

Reason for Medication(s) _____

If your camper must receive medication during his/her scheduled summer camping session, please complete this form and bring it along with the prescribed medication to camp with the camper. All medications and forms will be checked at camp registration on the start day of your camper's event. **NO Medication will be accepted unless his/her name is on the original prescription.** Campers using over the counter medications daily must have this form signed and brought to camp with the medication.

PRESCRIBING HEALTH CARE PROVIDER INFORMATION - I certify that it is imperative that the medication(s) prescribed below be taken during this child's camping session.

(Health Care Provider Name) _____ (Health Care Provider Signature) _____ (Phone) _____ (Date) _____

Medication Name(s) / Dosage(s)	Time(s) : B-Breakfast, L-Lunch, D-Dinner, HS-Bedtime
	<input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D <input type="checkbox"/> HS <input type="checkbox"/> Other _____
	<input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D <input type="checkbox"/> HS <input type="checkbox"/> Other _____
	<input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D <input type="checkbox"/> HS <input type="checkbox"/> Other _____
	<input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D <input type="checkbox"/> HS <input type="checkbox"/> Other _____

PARENT AUTHORIZATION

I, _____ give my consent to the Health Care
 (Name of Parent/Guardian)
 Staff to administer the above medication(s) to my child/camper _____
 (Name of Camper)
 during their time at Gretna Glen from _____ through _____
 (Starting Date) (Closing Date)

(Signature of Parent/Guardian) _____ Date _____

THIS SECTION COMPLETED BY HEALTH CARE STAFF ONLY

- Permission form completed Safety type container Original prescription label Name of child is on label
- Date on label is current OTC, original container and current Name of drug, dose, & frequency of admin on label
- Inhaler and/or Epi-Pen w/ camper (either with individual or counselor)

(Health Care Staff Approval) _____