Clinton Gymnastics Academy

STUDENT ASSISTED MEDICATION ADMINISTRATION AUTHORIZATION

This form is valid only for Summer Camp Season 2015 June to August at Clinton Gymnastics Academy.

This form must be completed fully in order for camp instructors to store and assist campers with self administration of required medication. A new medication administration form must be completed each year of camp for each medication, and each time there is a change in dosage of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- CGA does not assist with Non-prescription medication (cold, allergy).
  - A parent or guardian must administer all non-prescription medicine.
  - Campers must not possess non-prescription medication at camp.
- An adult must bring the prescription medication to the camp.
- The Health Advisor (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student:_____ Date of Birth:_____ Grade: _____

Condition for which medication is being administered: _____

Medication Name:_____ Dose:_____ Route: _____

Time/frequency of administration:_____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Prescriber's Name/Title:_____
(Type or print)
Telephone:_____ FAX: _____

Address:_____

_____

Prescriber's Signature:_____ Date:_____
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the Health Advisor (RN):Tamara Wilson for the above medication on (Date): _____

PARENT/GUARDIAN AUTHORIZATION

I/We request designated CGA Camp personnel to assist my child in self administration of the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the self administration of medication at Camp. I/We understand that at the end of the camp season August 2015, an adult must pick up the medication, otherwise it will be discarded.

I/We authorize the Camp Health Advisor to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature:_____ Date: _____

Home Phone #:_____ Cell Phone #:_____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Prescriber's authorization for self carry/self administration of emergency medication: _____
Signature Date