Medication Authorization and Emergency Action Plans
(To be signed by physician and parent/guardian)

Name of Camper _____ Age ____

Condition requiring Medication, EpiPen, Inhaler, or Insulin _____

Name of Licensed Prescriber _____

Prescriber Business Telephone _____

Prescriber Emergency Telephone _____

Parent/Guardian Name _____

Home Telephone _____

Work Telephone _____

Emergency Telephone _____

Name of Medication _____ Dose given at camp _____

Route of Administration _____ Frequency _____ Date Ordered _____

Duration of Order _____ Qty Received _____ Exp. Date of Meds Received _____

Special Storage Requirements _____

Can Patient Self-Administer this Medication (circle one): Yes / No

Specific Directions (e.g. on an empty stomach/with water) _____

Specific Precautions _____

Possible Side Effects/Adverse Reactions _____

Other Medications (at parents' discretion) _____

Location Where Medication Administration Will Occur _____

Emergency Action Plan:

Physician Signature _____ Date _____

I hereby authorize Camp Shemesh to administer, to my child _____ the medications listed above, in accordance with 105 CMR 430.160 (see following page).

Parent Signature _____ Date _____

[Admin Only on this page]

Camper: _____

Allergy to: _____

Severe Symptoms:

Action Plan:

Mild Symptoms:

Action Plan:

Notes:

Med Returned Date _____

Returned By _____