Medication Administration Record 1

Camper Name: _____
First Middle Last

Birth Date: _____
Month/ Day/ Year

Instructions to Parents/ Guardians

On the next pages of the Medication Administration Record form must be completed and signed by both you and the Authorized Prescriber (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse) for EVERY medication—whether over-the-counter (e.g., Advil) or prescription (e.g., Albuterol) - and each medication must have its own section. All over-the-counter medications must be in new, unopened container. There are non-prescription medication available in the Health Center at all times. You can find a list of the available medications on the Health Form.

Medication shall only be administered by the Health Officer, Summer Camp Director, or by a licensed health care professional authorized to administer prescription medications. The health care consultant shall acknowledge in writing the list of medications administered at the camp. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall beunder the professional oversight of the health care consultant. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.

Health Officer– A person who is at least 18 years of age, specifically trained and at least current in Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.

<u>Information about Medication Distribution:</u>

- Medications must be in the original container and labeled with child's name, name of medication, direction for medication's administration, and date of the prescription. All unused medication will be destroyed if not picked up within one week following the camper's departure from camp.
- Campers are not allowed to have any medications (prescription or non) in their cabin.
- Counselor will carry any emergency medications (Epi-pen or inhaler) and will be with that camper at all times. All other medications will be carried by the Health Officer or other approved camp staff and stored in a locked cabinet.
- Medication requiring refrigeration will be kept in the refrigerator locked in the Health Center.
- The Health Officer is not available 24/7 for routine medication distribution. There will be normal dosing times that are just prior to meals and before bed.
- If dosing requirements mandate something other than the routine frequency please contact the Camp Office to find out if that schedule can be accommodated.

I have read the above and agree to abide by the requirements.

Signature of Parent/ Guardian _____ Date: _____

Medication Administration Record 2

Camper Name: _____
First Middle Last

Birth Date: _____
Month/ Day/ Year

Parents/ Guardians: Please fill in medication information in blocks on left only. Please place medications **In Original Containers** into a sealable plastic bag that is clearly labeled with you campers name, date of birth, and allergies written in permanent marker on the out-side of the bag. Medications must be in original container with doctors directions if it is prescription (please no pills in bags or daily dispens- ers). Please send inhaler if your child has asthma. Please send Epi-Pen if your child has a history of severe allergic reactions.

Authorized Prescriber: The medication, dosage, and frequency to the left are for you to fill out.
Healthcare Provider: The date and time blocks to the right are for you to chart when medication **Was** given. (Missing
Dose Legend: R= refused medication, S= skipped dose for medical reasons, N= no show)

Camp Dates:	Dose	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Medication: _____	Breakfast							
_____	Lunch							
Dosage: _____	Dinner							
_____	Bed							
Frequency: _____								
_____								

Medication: _____	Breakfast							
_____	Lunch							
Dosage: _____	Dinner							
_____	Bed							
Frequency: _____								
_____								

Medication: _____	Breakfast							
_____	Lunch							
Dosage: _____	Dinner							
_____	Bed							
Frequency: _____								
_____								

Medication: _____	Breakfast							
_____	Lunch							
Dosage: _____	Dinner							
_____	Bed							
Frequency: _____								
_____								

Medication: _____	Breakfast							
_____	Lunch							
Dosage: _____	Dinner							
_____	Bed							
Frequency: _____								
_____								

Authorized Prescriber Signature: _____ Date: _____

Signature of Parent/ Guardian _____ Date: _____

Medication Administration Record 3

Camper Name: _____
First Middle Last

Birth Date: _____
Month/ Day/ Year

Allergies: _____

_____

_____

_____

_____

I give Camp Albemarle, and its staff permission to administer medications as prescribed for my camper as named and listed on the MAR

Medications Checked into camp by: _____ / _____
Parent/ Guardian Signature and Date — Health Officer Signature and Date

Medications Checked out by: _____ / _____
Parent/ Guardian Signature and Date — Health Officer Signature and Dat

Only For Staff Members Dispensing Medications Below

Name (*readable)*	Signature	Initials

Notes: _____

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_____

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_____

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