

STATE PROCEDURES REGARDING MEDICATIONS

Campers must surrender all medication, **EVEN OVER-THE-COUNTER MEDICATION** (i.e. Tylenol, Advil, etc) to our Medical Staff at check-in, to be placed in a locked medical box for the duration of the camp. Campers may self-administer prescribed medications when needed with documented parental and authorized prescriber permission. Prescription medications **must** be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber or dentist's name and date of the original prescription. Over-the-counter medication must be in the original container and labeled with the child's name.

I hereby request that the following medication be self-administered by:

_____, during CC Volleyball Camp.
(PLEASE PRINT CAMPER'S NAME) (DATE)

I understand that I must supply the youth camp with the prescribed medication in it's original container and properly labeled by a physician/pharmacist. Over the counter medication shall be labeled with the child's name by the Parent/Guardian(s) at check-in. I understand that this medication will be destroyed if not picked up within (1) week following the end of this session of camp.

Name of Medication: _____

Times of Administration: _____, _____, _____ Dates of Administration: ___/___/___ to ___/___/___

Is this a controlled drug? _____

Authorized Prescriber or Dentist Information:

Name (PRINT): _____ Phone #: _____

Street Address: _____ City/Town: _____ State: _____

Authorized Prescriber or Dentist Signature: _____

Parent/Guardian(s) Name (Printed): _____

Parent/Guardian(s) Signature: _____

Relationship to child: _____

Phone Number: _____

THIS SIDE TO BE FILLED OUT BY CAMP STAFF ONLY!

Name of Child: _____ Room #: _____

Group: _____ Coach: _____

Medication Name: _____

Date: ___/___/___ Time: _____ AM/PM Dosage: _____ Strength: _____ Trainer: _____

Comments: _____

Medication Name: _____

Date: ___/___/___ Time: _____ AM/PM Dosage: _____ Strength: _____ Trainer: _____

Comments: _____

Medication Name: _____

Date: ___/___/___ Time: _____ AM/PM Dosage: _____ Strength: _____ Trainer: _____

Comments: _____

Medication Name: _____

Date: ___/___/___ Time: _____ AM/PM Dosage: _____ Strength: _____ Trainer: _____

Comments: _____

Medication Name: _____

Date: ___/___/___ Time: _____ AM/PM Dosage: _____ Strength: _____ Trainer: _____

Comments: _____
