MEDICATION ADMINISTRATION RECORD 1

Camper Name: _____ (First / Middle / Last)

Birth Date: _____ (Month/ Day/ Year)

Instructions to Guardians, Campers & Physicians/Authorized Prescriber's:

The next pages of this Medication Administration Record ***must be completed and signed by both the Guardian AND Authorized Prescriber (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse) for EVERY medication***—whether over-the-counter (i.e. Advil) or prescription (i.e. Albuterol) - and each medication must have its own section. Medication prescribed for campers shall only be administered if it is from the original container, and there is written permission from the parent/ guardian AND the Authorized Prescriber. All over-the-counter medications you expect your camper will use while at camp MUST be provided by you, and must be brought to camp in new, unopened containers. Shekinah Ranch Camp will only supply OTC medication to campers in the event of an emergency, and these can only be administered with a written Physician's approval (See Record 3 in packet). Medication shall be **self-administered** by campers, and will be monitored by a Health Officer*. The Health Officer shall acknowledge and keep record in writing of the medications administered at the camp. ***Health Officer–** A person who is at least 18 years of age, Medication Administration trained (has been trained in the administration of medications) and is current in First Aid and CPR, authorized to supervise camper self-administration of prescription medications.

Information about Medication Distribution:

- Prescribed 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.
- Campers must carry any emergency medications (Epi-pen or inaheler) on their persons at all times. All other medications will be stored in a locked cabinet.
- Medication requiring refrigeration will be kept in the Staff refrigerator
- 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.

Medication shall be administered from: _____/_____/_____ to _____/_____/_____. (M/D/Y)

Please be advised that SRC staff are not trained medical professionals. SRC Staff will rely upon the child to recognize the development of symptoms/ time medication should be administered, and to self-administer all medications (excluding emergencies i.e. epi-pen/inhaler) under the supervision of an SRC Health Advisor.

In your opinion, does the child know the following?

Nature of his/her condition? YES NO

How to self-administer required medication? YES NO

When to self-administer required medication? YES NO

Do you approve your child be allowed to self-carry prescribed medication? YES NO

Guardian Name _____

Guardian Signature _____ Date:_____

Authorized Prescriber Name (PRINT)_____

Authorized Prescriber Signature _____ Date:_____

Authorized Prescriber Phone Number _____

Medication Administration Record 2
-Prescription Medication-

Camper Name: ______________________________
First Middle Last

Birth Date: ______________
Month/ Day/ Year

Authorized Prescribers: Please fill in medication information in blocks on left only, **and initial in the far right box for each medication**
Guardians: Medications must be in original container with doctor's directions if it is prescription (please no pills in bags or daily dispensers**).** Please place medications into a sealable plastic bag that is clearly labeled with you camper's name, date of birth, and allergies written in permanent marker on the out-side of the bag. Please send inhaler if your child has asthma. Please send Epi-Pen if your child has a history of severe allergic reactions.

Camp Health Advisor Staff: The date and time blocks to the right are for you to chart when medication was self-administered and supervised. (Self Administered Key: T- Taken in Full/Correct Dosage R= refused medication, S= skipped dose for medical reasons, N= no show)

Camp Dates:	Dose	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	**INITIAL**
Medication: ______________	Breakfast							
______________	Lunch							
Dosage: ______________	Dinner							
______________	Bed							
Frequency: ______________								
______________								
Comments:								
Medication: ______________	Breakfast							
______________	Lunch							
Dosage: ______________	Dinner							
______________	Bed							
Frequency: ______________								
______________								
Comments:								
Medication: ______________	Breakfast							
______________	Lunch							
Dosage: ______________	Dinner							
______________	Bed							
Frequency: ______________								
______________								
Comments:								
Medication: ______________	Breakfast							
______________	Lunch							
Dosage: ______________	Dinner							
______________	Bed							
Frequency: ______________								
______________								
Comments:								
Medication: ______________	Breakfast							
______________	Lunch							
Dosage: ______________	Dinner							
______________	Bed							
Frequency: ______________								
______________								
Comments:								

Authorized Prescriber Signature: ______________________________ Date: ______________

Medication Administration Record 3
- Over The Counter (OTC) Medication -

Camper Name: ______________________________
First Middle Last

Birth Date: ____________________
Month/ Day/ Year

Authorized Prescribers: Please fill in medication information in blocks on left only, **and initial in the far right box for each medication**
Guardians: Please place **UNOPENED** medications **in Original Containers** into a sealable plastic bag that is clearly labeled with your campers name, date of birth, and allergies written in permanent marker on the out- side of the bag.

Camp Health Advisor Staff: The date and time blocks to the right are for you to chart when medication was **self-administered** and supervised.
(Self Administered Key: T- Taken in Full/Correct Dosage R= refused medication, S= skipped dose for medical reasons, N= no show)

Camp Dates:	Dose	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	**INITIAL**
Medication: ____________	Breakfast							
____________	Lunch							
Dosage: ____________	Dinner							
____________	Bed							
Frequency: ____________								
____________								
Comments:								
Medication: ____________	Breakfast							
____________	Lunch							
Dosage: ____________	Dinner							
____________	Bed							
Frequency: ____________								
____________								
Comments:								
Medication: ____________	Breakfast							
____________	Lunch							
Dosage: ____________	Dinner							
____________	Bed							
Frequency: ____________								
____________								
Comments:								
Medication: ____________	Breakfast							
____________	Lunch							
Dosage: ____________	Dinner							
____________	Bed							
Frequency: ____________								
____________								
Comments:								
Medication: ____________	Breakfast							
____________	Lunch							
Dosage: ____________	Dinner							
____________	Bed							
Frequency: ____________								
____________								
Comments:								

Authorized Medical Professional:______________________________ Date: ____________________