



WESTERLY - PAWCATUCK YMCA MEDICATION FORM

Prescription Medications:

Rhode Island State Law requires that the following form be completed and signed by a parent/guardian AND the prescribing doctor in order for a trained and certified staff member to administer prescribed medications during camp operating hours. All medications must be in a pharmacy labeled container with the name of the child below as the prescribed, name of the drug, strength, dosage, frequency, authorized prescriber and the date of the original prescription. This includes epi-pens and asthma inhalers – make sure you send the box with the medication if the label is on the box!

Over the Counter (OTC): All over-the-counter medications must be in the original container and labeled with the camper's name. This form must be completed but does NOT need to be signed by your physician. We do stock a small number of OTC medications which are listed on the registration form. Only these medications do not require this form and are administered under the Standing Orders of the on-call camp physician.

Medications MUST be delivered by the authorizing parent/guardian. You may NOT send medications with your child to camp. All medications are kept in locked storage and can only be accessed by designated personnel. Certain medications such as inhalers and epi-pens may be allowed to be carried by the camper or a counselor at the Program Director's and parent's discretion.

Camper Name:		Age:	
Date of Birth:	Guardian:		Relationship:
Address:			
City:		State:	Zip:
Home Phone:		Cell Phone:	

MEDICATION INFORMATION:

Medication Name _____ Dose _____

Method _____ Time _____

Administered between these dates _____

Relevant side effects to be observed, if any _____

If side effects, plan for management _____

Is this a controlled drug? _____ Allergies or interactions with other food/drugs _____

If "When Needed" describe indications _____

PARENT/GUARDIAN'S AUTHORIZATION

I hereby request that the above medication, approved and ordered by an authorized doctor for my child be administered by the camp health provider during day camp operation hours specified above. I understand that I must supply the camp with the appropriately prescribed medication in the original container dispensed and properly labeled by an authorized prescriber. Over the counter medications will be in their original packaging and have my child's full name clearly labeled.

I understand that if not picked up, this medication will be destroyed after one (1) business week following the termination of the order or end of participation in YMCA programs.

I give my child permission to self-administer his/her prescribed inhaler or epipens as directed by the child's physician. Yes ☐ No ☐

Parent/Guardian Signature: _____ Date: _____

PHYSICIAN'S AUTHORIZATION (required for prescribed medications not OTC's)

Print Name of Physician: _____ Phone: _____

City _____ State _____ Zip _____

I have prescribed the above medications to this child. YMCA Camp Watchaug has been informed of all necessary information regarding this child's medication, side effects, and any other pertinent medication information necessary for a standard of care.

Physician's Signature : _____ Date: _____