Medication Authorization Form Occohannock on the Bay Camp and Retreat Center

Over- the- Counter and Prescription Medications

OFFICE: (757) 442-7836 FAX: (757) 442-3030

I, ________________________, parent/guardian of _______________________, give the staff of Occohannock on the Bay Camp and Retreat Center (OOTB) permission to administer the following prescribed medications and over- the- counter medications to my child during program hours.

I agree to provide the medication to the camp in the original container labeled with the camper's name, physician's name, name of the medication, the amount and time it is to be given, with the label intact.

I have been provided patient information on these medications by the pharmacist that filled the prescription and I am aware of the possible side effects of these medications. I understand and accept that OOTB is not responsible for any side effects of the medication administered.

I understand and accept that I will not hold OOTB or its employees, volunteers, or designees responsible for any negative outcomes from self- administration of any inhaled asthma medications, nasal sprays, and/ or topical creams.

Also, please note that OOTB does NOT administer any over- the- counter medications/ prescription medications that are not in the original container, expired, or provide any dosage that exceeds what is recommended on the container, unless a doctor's signature is provided. OOTB will also follow what is stated on the prescription label unless a doctor's note is provided stating that there has been a change in the prescription.

List all known allergies and known reactions: ____

Prescription and Regularly Scheduled Medications:	**As Needed Medications:**
Name of medication: ______________ Dosage: ______________ Time of Administration: ______________ Purpose of Medication: ______________ Name of Prescribing Physician: ______________ Physician Phone: ______________	Name of medication: ______________ Symptoms needed for administration: (please check all that apply) HEADACHE ☐ MUSCLE PAINS ☐ STOMACHACHE ☐ PAIN ☐ CRAMPS ☐ OTHER: ______________ Frequency to be administered: ______________ Dosage: ______________
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With my signature I understand and accept that OOTB employees, volunteers, or designees are not responsible for any effects of the medications administered. I agree to furnish the said medications in the ORIGINAL container supplied by the pharmacy with the label intact.

Parent/Guardian Signature: ______________________ Date: ________ Home_______________ Cell ____________

If you have a medication that exceeds the recommended dosage or there has been a change in the prescription, but not on the label, please have a physician fill out the Supplemental Medication Authorization form