



## Beachmont Christian Camp

6433 Mt. Vista Road Kingsville, MD 21087 Phone(410)592-3648 Fax(410)592-3616

### Physician's Medication Order Form

*For campers with severe/life-threatening **Food Allergies**, please complete a Food Allergy Action Plan instead of this form.*

**TO THE PARENTS:** Please have this form completed by your child's physician and have it sent to our office prior to camp. No medication will be administered to your child without this completed form.

**TO THE PHYSICIAN:** Please complete this form for the child below. It is a form requesting prescription medication to be administered to the child during our Summer Day Camp program.

Child: \_\_\_\_\_  
*Last Name* *First Name* *M.I.*

Medication and dosage: \_\_\_\_\_

When to be administered: \_\_\_\_\_ To be administered with: \_\_\_\_\_

Side effects: \_\_\_\_\_

List any reasons for not giving medication (vomiting, fever, etc.) \_\_\_\_\_

\_\_\_\_\_  
*Signature of Physician* *Date* *Physician's Phone*

All prescription medication must be in the original container bearing a pharmacy label which shows the prescription number, date filled, prescribing physician's name, name of medication, directions for taking the medication and the patient's name.

- Yes, my child has received at least one dose of this medication at home or prior to camp time.  
 My child can self-administer this medication (under supervision of camp nurse or an adult staff member designated by nurse).

**I authorize and request Beachmont Christian Camp to administer the medication prescribed by my child's physician, and in doing so relieve the camp, its agents, employees or representatives of any responsibility for ill effects which may result from the administering of said prescribed medication.**

\_\_\_\_\_  
*Signature of Parent or Legal Guardian* *Date* *Home Phone*

**FOR DIABETIC PATIENTS:** Please attach a detailed description of present condition including all pertinent information (insulin information, blood glucose monitoring, snacks, emergency food, equipment to be brought to camp, special circumstances, restrictions, etc.). This information may be completed by the physician *or* parent, but must be attached as part of this form *prior* to the physician signing this form.

#### MEDICATION ADMINISTERED

Date	Time	Camp Nurse Initials

Date	Time	Camp Nurse Initials

**Final disposition of medication listed above:**

Disposition action: \_\_\_\_\_ Date: \_\_\_\_\_ Released by: \_\_\_\_\_  
 Rev. 2/2006 JKK *(initials)*