The following information is necessary for any camper to possess or use prescribed medications or treatments or non-prescription medication during camp (BOTTOM OF FORM MUST BE SIGNED).

REQUEST FOR ASSISTANCE IN THE ADMINISTRATION OF MEDICATION
BEACHWOOD DAY CAMPS

I hereby request and give permission to designated personnel to help in the self-administration of medication to my child.

Camper Name_____ Home Phone ( ) _____

Address _____ Emergency Phone ( ) _____

Camp Program _____ Date of Birth _____

I am sending medication **in the original container** from our physician or pharmacist.

(Please send only medicine that your child currently needs)

I understand and acknowledge that an employee of the camp who is not medically trained may render such assistance. There will not be any designated personnel available for procedures for which specific medical training is necessary. I hereby release and hold harmless the City of Beachwood and/or its sponsors, volunteers, and employees from any and all liability for damages directly or indirectly resulting from this assistance. I agree to submit revised signed statement if this information should change before my child attends camp.

Check type of medication

_____ Physician prescribed medication _____ Non-prescription medication

Please list the name of medication to be administered, the dosage, and the time of day or intervals dosage of drug is to be administered. If generic drug is sent, both names are necessary.

Name of Drug and Generic Name Dosage Time/Intervals

_____

_____

_____

Reason medicine is needed _____

Possible adverse reactions that, it they occur, should be reported to the parent or physician

_____

Date medication administration begins _____ Date medication administration ceases _____

Special instructions for administration or storage of medication _____

Physicians Name _____

Physicians Address _____

Physicians Phone Number ( ) _____

_____ ( ) _____ Date _____

Parent/Guardian Signature **Parent/Guardian Phone**