

CAMP PELICAN

2010 SEASON

Dear Parent,

We look forward to seeing your camper this season. According to our records, your camper requires the enclosed medical authorization form on file.

The health department requires us to obtain the enclosed release form for each camper who will or may receive prescription medication at camp. This form is in addition to the standard medical form required for every camper.

Please fill out Section A and ask your health provider to complete and sign Section B. Incomplete and/or unsigned forms will not be accepted by the health department.

According to state law, all medication at camp must be sent in and kept in the properly labeled original container from the pharmacy.

A standard medical form is mandatory for all campers and can be found in the forms & news section at our website, www.pelicandaycamp.com. Please have it completed and returned as soon as possible. The health department requires a parental signature along with information provided by your family physician. If you would prefer to have a form mailed to you, please call us.

Thank you for your consideration in this matter. Please contact us anytime if you have any questions. We look forward to seeing everyone soon.

Sincerely,
The Staff of Camp Pelican

Enc.

PARENT AND PRESCRIBER'S AUTHORIZATION FOR
ADMINISTRATION OF MEDICATION AT **CAMP PELICAN**

Authorization for administration of medication

A. To be completed by the Parent or Guardian:

I request that my child _____ attending **Camp Pelican** receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the camp nurse or other designated person, in the case of the absence of the camp nurse, will administer the medication.

Signature (Parent or Guardian): _____

Address: _____

Telephone: _____ Date: _____

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Name of Camper: _____ Date of Birth: _____

Diagnosis: _____

Name of medication: _____

Prescribed Dosage and Means of Administering: _____

Time to be taken during camp hours: _____

Expected Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

Other Recommendations (including PRN or self-administration orders): _____

Name and Title of Licensed Prescriber (please print): _____

Signature: _____ Date: _____

Address: _____ Phone: _____