The Mountaineers
www.mountaineers.org

Medication Authorization Form

SELF ADMINISTERED MEDICATION – for non-controlled PRN prescription medications (such as epipens and inhalers)

My child has permission to carry and self administer the medication listed below:

Child's Name_____

Name of Medication: _____ Dose: _____

When Medication Should Be Taken: _____

What Happens If Medication Is NOT Taken: _____

_____

_____

OVER THE COUNTER MEDICATION PERMISSION – for all non-prescription medications, including topical ointments.

I give permission for leaders to distribute the following over the counter medication to my child:

Name of Medication: _____ Dose: _____

When Medication Should Be Taken: _____

Name of Medication: _____ Dose: _____

When Medication Should Be Taken: _____

Name of Medication: _____ Dose: _____

When Medication Should Be Taken: _____

Name of Medication: _____ Dose: _____

When Medication Should Be Taken: _____

Note: All medications, including OTC Medications must be in their original bottle, labeled with the camper's first and last name, and must be current (not expired). Mountaineers leaders will distribute parent-indicated dosage or recommend dosage on label, whichever is less.

Parent Signature: _____ Date: _____

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Sunscreen & Hand Sanitizer Authorization Form

I give permission for the Mountaineers staff and volunteers to administer sunscreen and/or hand sanitizer to my child at their discretion. I assert that my child has no known allergies to any brands of sunscreen or hand sanitizer, and acknowledge that allergies can develop at any time. I understand that The Mountaineers staff and volunteers will make every attempt to help campers prevent sunburn, but a Medication Authorization Form with specific dosages is required for application beyond reasonable periodic applications.

"I hereby give representatives of The Mountaineers permission to apply:

(initial) _____ any brand of non-prescription Sunscreen

(initial)_____any brand of non-prescription Hand Sanitizer

At their discretion to my child."

_____

Youth Name

_____ _____

Parent Signature Date

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Authorized Prescriber's Order for Medication Administration

Authorized Prescriber's Order
(Physician, Dentist, Physician's Assistant, Advanced Practice Registered Nurse)

PRESCRIPTION MEDICATION PERMISSION – for all prescription medications, including controlled, non-controlled and self-administered medications

Child's Name_____ Birth Date _____ Today's Date_____

Medication Name_____ Controlled Drug? **Yes / No**

Condition for which drug is administered_____

Dosage _____ Method_____ Times of administration:_____

Any specific instructions for medication administration: _____

Medication Administration: Start Date _____ End Date _____

May this medication be self-administered by the child? **Yes / No**

Relevant side effects of medication_____

Plan for management of side effects _____

Known Camper Allergies _____

Prescriber Information & Signature

Printed Name_____Phone:_____

Address (Street, City, State, Zip)_____

Prescriber signature:_____ Date:_____

Parent/Guardian Information & Signature
Authorizing administration of medication as described and directed above

Printed Name_____Phone:_____

Address (Street, City, State, Zip)_____

Parent/Guardian signature:_____ Date:_____