OAK HILL
SCHOOL

Camp Wild Oaks Summer Programs Over the Counter Medication Administration Authorization

Prescription medications require the completion of a separate, specific permission form, which is included with these registration forms. All prescription medications must be in the student's name and must be contained in the original pharmacy container.

Student Name: _____

Parent/Guardian Name: _____

As parent(s)/legal guardian(s) of said student, I/we give OHS Staff permission to administer the following as needed: ***Check all that apply.***

Acetaminophen (Tylenol) □Yes □No Ibuprofen (Advil) □Yes □No Neutralin (Antacid) □Yes □No Benadryl (Allergy) □Yes □No Tecnu (anti-itch cream for symptoms of poison oak) □Yes □No

Additional over the counter medications student may use at camp: (medication must be kept in the office):

Print: Parent/Guardian Name(s) _____

Signature(s) of Parent/Guardian(s)_____ **Date:**_____

Camp Wild Oaks Summer Programs Prescription Medication Administration Authorization

Today's Date: _____ Child's Name:_____

Date of Birth: _____ Physician Name:_____

Notification of Chronic Conditions/Illnesses:

Dear Oak Hill School Summer Personnel:

This child has the following medical condition(s), which necessitate the administration of medication(s) during regular camp hours:

Primary Medical Diagnosis: _____

_____

Additional Medical Diagnoses: □ None, or:_____

_____

(Child's Name:) _____ has my permission to receive the following medication(s) during camp hours:

Medication #1:

Trade Name: _____

Generic Name: _____

Dosage & Schedule: _____

_____

If "as needed", when to give: _____

_____

_____

If "as needed", when to call parent: □ if used, or: _____

_____

_____

Potential Side Effects: _____

_____

_____

Child May / May Not carry his or her own medication

Medication #2:

Trade Name: _____

Generic Name: _____

Dosage & Schedule: _____

_____

If “as needed”, when to give: _____

_____

_____

If “as needed”, when to call parent: □ if used, or: _____

_____

_____

Potential Side Effects: _____

_____

_____

Child May / May Not carry his or her own medication

Medication #3:

Trade Name: _____

Generic Name: _____

Dosage & Schedule: _____

_____

If “as needed”, when to give: _____

_____

_____

If “as needed”, when to call parent: □ if used, or: _____

_____

_____

Potential Side Effects: _____

_____

_____

Child May / May Not carry his or her own medication

Reminder: All prescription medications administered to students during the camp day must be provided to the Oak Hill Auxiliary Programs office by the parent or guardian in the original pharmacy bottle, with a pharmacist instruction label that is current and that names the student. Prescription medications will be stored in a locked enclosure with access limited to only those staff designated as a student health liaison.

Parent(s) Name (Printed):_____

Parent(s) Signature:_____ Date:_____