COLORADO MOUNTAIN RANCH SUMMER DAY CAMP (CMR) Office: 303-442-4557

PRESCRIPTION MEDICATION CONSENT FORM (Optional)

(*Required for prescription medication to be administered at Camp)*

THIS FORM IS NOT DUE WITH REGISTRATION, BUT MUST BE ON FILE BEFORE MEDICATION ADMINISTRATION AT CAMP

CAMPER'S NAME_____

Administration of Prescription Medication at the Colorado Mountain Ranch (CMR)

Separate forms are required for <u>each</u> medication

The parent/guardian of_____authorizes CMR Staff to give to the
(Please print child's full name)

following medication_____at_____
(Name of Medication & Dosage) (times)

to my child, according the licensed health care provider with prescriptive authority's signed instructions below.

The Colorado Mountain Ranch agrees to administer medication as prescribed by the trained Medication Administrator.

Prescription medications must come in an original pharmacy container labeled with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, along with the name of the prescribing authority. The pharmacy name and phone number must also be included on the label. Pharmacists may provide a separate bottle with a complete printed label to keep at the Ranch for the week. Any unused medications will be available for parent pickup from the Bus Stop each Friday afternoon.

By signing this document, I give permission for my child's health care provider with prescribing authority to share information about the administration of this medication with staff delegated to administer medication.

_____ _____ ___/___/_____
(Print Parent/Legal Guardian's Name) (Parent/Legal Guardian's Signature) (Date)

Phone #1_____ Phone # 2_____ Email_____

Prescription Authority's Authorization to Administer Medication at the Colorado Mountain Ranch (CMR)

Please Print

Child's Name_____Birthdate_____
Medication_____
Dosage_____Route_____
To be given at the following time(s) _____
Special Instructions_____
Purpose of Medication_____
Side effects that need to be reported_____
Starting Date_____ Ending Date_____

X_____ Date_____
(Signature of Heath Care Provider with Prescriptive authority)

Clinic Name and Phone Number_____