Medication Self-Carry/Self-Administer Authorization

(by Child, Parent, and Prescribing Physician or Health Care Provider)

For children 17 & younger who need to carry emergency medications (inhalers/epi-pens) while at Summer Camp

This agreement is for children diagnosed with asthma, anaphylaxis, severe allergies, and/or other life-threatening conditions. The Colorado Mountain Ranch Summer Day Camp requires this document to be completed and signed by the Child and Parent or Guardian. The child's Physician or Health Care Provider must sign this form or provide Doctor's Medication Orders. All medication forms will be reviewed and signed off by the Camp Counselor and Camp Health Care Staff. All documents will be kept on file in the Camp Office.

Child's Name: _____ **Date of Birth:** _____

Medication(s): _____

Purpose of Medication(s) _____

Child

- I agree to keep my medication with me while at camp and use it in a responsible manner.
- I will notify Camp Health Staff immediately if my condition for which I am prescribed my medication presents any unusual difficulty or symptoms.
- I will not allow any other camper to administer or use my medication.
- If I am authorized to self-administer, I will be sure to notify Camp staff when I use my medication.
- I understand that if I fail to comply with this contract, my privilege to carry and/or self-administer the medication may be withdrawn.

Child's Printed Name _____

Child's Signature _____ **Date** _____

Parent or Guardian

- I assure that my child will carry their medication as prescribed, that the medication will be appropriately labeled by a pharmacist or health care provider and that the medication has not expired.
- I will assure that the Camp is provided two sets of medication, one for my child and one as back-up medication for the camp health staff for emergencies.

Parent/Guardian Printed Name _____ Phone #_____

Parent/ Guardian Signature _____ **Date** _____

Physician or Health Care Provider Check all that apply:

_____I assure that the child listed above needs the listed medication.

_____I assure that the child is aware of the proper procedure to self-administer & can do so as needed.

Health Care Provider Printed Name _____ Phone #_____

Health Care Provider Signature_____Date_____

This information is required by the State of Colorado Department of Human Services, Division of Early Learning and Care, Office of Child Care Licensing, Colorado Child Care Regulation 7.711.31.4. Questions about this additional paperwork can be directed to the State of Colorado Department of Human Services, Office of Early Childhood at 303-886-5948 or cdhs_oec_communications@state.co.us

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