

## 4-H CAMP MEDICATION/FOOD ALLERGY

**To be filled out in full by ALL campers PRIOR to attending camp.**

1. **All prescription** medications must be turned in to camp nurse and must be dispensed by camp nurse.
2. The medication must be in **original, completely labeled container, bearing the pharmacy label.**
3. A parent/guardian must complete and sign this permission form before the camp nurse will give the medication.
4. All medications will be kept at the nurse's station.
5. It may be necessary to administer over-the-counter medications for incidents that occur at camp, such as scrapes, bug bites, poison ivy, diarrhea, nausea, headache and discomfort that goes along with the above ailments. We need your permission to give medications if your child needs them.
6. Inform the office if any medical information has changed on the KS 4-H Participation form filled out when you enrolled.

Camper's Name: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Office (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_

Medication	Reason for Medication	Dose Amount	Frequency/Time				Comments:
			M	L	D	B	
<i>Ex.: Zyrtec</i>	<i>Allergies</i>	<i>5 mg</i>			<i>X</i>		<i>On a full stomach</i>

\*M=morning L=lunch D=dinner B=bedtime\*

Allergies/Food Allergies: \_\_\_\_\_

**I grant permission and request the camp nurse at Coffey County 4-H Camp to administer the prescription medication listed above and/or over-the-counter medication checked below to my child according to instructions.**

\_\_\_\_\_ Acetaminophen (generic Tylenol)      \_\_\_\_\_ Antihistamine (generic Benadryl)

\_\_\_\_\_ Ibuprofen (generic Motrin)

OR

\_\_\_\_\_ **Please contact me for permission to administer any over-the-counter medication if my child has health complaints.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_