Arkansas District UPCI Medication Administration Permission Form

As the parent/guardian(s) of _____ I authorize the camp nurse to administer the following medication(s) on this form my child as provided. I understand all medication must be labeled and in its actual container (pharmacy or over the counter) with directions clearly written.

We, I, do hold the camp nurse, camp officials, or Arkansas District and/or officials harmless of any liability regarding these medications as they will be given as prescribed on the medication label. I understand that if I do not have medication(s) in their original bottles or packets that nursing staff will not be responsible for any medication errors, as they will be giving medication as I have instructed and signed off on below. I do not hold camp or nursing staff responsible if I chose to leave my child's medication with another adult on the camp ground or in my child's dorm. I understand that nursing staff cannot get into dorms, cabins, or campers without security or access from owners. This will cause a delay in care. If I chose to leave medications with my child I am responsible for any lost medication(s), missing doses, and can be criminally charged should another child/camper take my child's medication and need medical attention.

Parent/Guardian Print Name:	Parent/ Guardian Signature:
Parent/ Guardian Phone Number(s):	If camper will have a cell phone at camp we need their number:

Medication Administration Record For the Week of June_____, 20_____-June_____, 20_____

Parent/Guardian(s) please fill in the following information. If you need more space please print another form and attach. Please leave the gray area's blank for camp nurses use.

Campers Name:	Date of Birth:	Allergies:	Dorm :	Sponsor & Phone #:

Nurse(s) time and initial after each medication dose is given in the gray area provided.

Medication Name	Dosage	Directions	Monday		Tuesday		Wednesday		Thursday		Friday	
Ex: Depakote 125mg	*1 tablet*	*Three times daily 7:00 a, 12:00 p, 7:00 p*		*1900*	*0700*	*1900*	*0700*	*1900*	*0700*	*1900*	*0700*	
					1200		*1200*		*1200*			

Nurse Signature:_____ Initial: _____	Nurse Signature:_____ Initial: _____
Remaining Medication was given to _____ Date:_____Time:_____ Their Initials:_____ Nurse Initial:_____	Medication Page _____ of _____