MEDICATION RELEASE WAIVER

Child’s Name: ____________________________________________________________

Does the child require prescription medication during summer camp hours?
Yes: ____ No: _____

If YES, parent or guardian complete the following:

I, ________________________, the parent/guardian of _____________________
(Print parent name) (Print campers name)
hereby request that identified members of the camp staff be caretakers of medication and
administrators of prescribed medication for the camper named above and as prescribed by my
physician.

______________________________________     ______________________________
Physician’s Name   Physician’s Phone Number

I understand that members of the camp staff will be instructed to take any medication from the
camper upon arrival at the camp and secure it in a safe location.

I understand that at a prescribed time, a staff member will retrieve the medication and hand it to
the camper in the container. The staff member will then watch the camper take the medication.

I understand the Authorization for Prescription Medication Form must be fill out completely and
signed by the camper’s doctor before the start of camp.

I also understand the staff who administers this medication are medically untrained. I hereby
state, without reservation that I will not hold the Calvert County Natural Resources Division, or
any of their employees and volunteers liable for any harm or injury which may be incurred by
the camper in connection with this medical assistance, or damage/loss of medical equipment.

__________________________________________  ___________________________
Signature of Parent/Guardian                                Date

OFFICIAL USE ONLY:
DATE RECEIVED: ____________________STAFF INITIALS: ______________________

CAMP ____________________ LOCATION ______________________
CAMP ____________________ LOCATION ______________________
CAMP ____________________ LOCATION ______________________
AUTHORIZATION FOR PRESCRIPTION MEDICATION

Does the child require prescription medication during summer camp hours? Yes: ____ No: ____

If YES, child's **physician** **MUST** complete the following:

Child's Name: ______________________________________________________________________

a.) Condition: ____________________________________________________________________

Medication: ___________________________________________________________________

Dosage / Schedule: ______________________________________________________________

Special Instructions: __________________________________________________________________

Side Effects / Toxic Effects: ______________________________________________________

b.) Condition: ____________________________________________________________________

Medication: ___________________________________________________________________

Dosage / Schedule: _____________________________________________________________

Special Instructions: __________________________________________________________________

Side Effects / Toxic Effects: ______________________________________________________

Date of Order: ________________________     Duration of Order: ____________________________

(If duration is less than current camp program, renewal of order may be necessary.)

I hereby authorize the camp staff to dispense these medications as prescribed.

__________________________________________________________________________
Printed Name of Physician                       Phone Number

__________________________________________________________________________
Signature of Physician                                                              Date

**OFFICIAL USE ONLY:**

DATE RECEIVED: ____________________STAFF INITIALS: ______________________

CAMP __________________________________________ LOCATION ___________________

CAMP __________________________________________ LOCATION ___________________

CAMP __________________________________________ LOCATION ___________________

Maryland Relay for Impaired Hearing or Speech: 1-800-735-2258
EPINEPHRINE (EPI-PEN) TRAINING ACKNOWLEDGEMENT

Will the child require epinephrine during summer camp hours?  Yes: ____ No: ____

If YES, parent or guardian MUST provide training to camp staff:

I _______________________________________________________, have been trained by
(Employee)

_____________________________________________ to administer Epinephrine and/or to

Parent(s)/Guardian(s)/Designee(s)

provide other emergency care to ________________________________________, a child
enrolled in a Calvert County Natural Resources Division Summer Camp, in the event the child
has been exposed to ____________________________ and is at risk of anaphylactic
reaction, or if the child exhibits the symptoms described in the POLICY: ADMINISTERING
EMERGENCY TREATMENT TO CHILDREN WITH SEVERE ALLERGIES which is
attached to and made a part of this Acknowledgement.

Date of Training: ____________________________

Signature: ________________________________

(Employee)

Signature: ________________________________

(Parent(s)/Guardian(s))