Game On Camps & Clinics, LLC
PO BOX 668
STORRS, CT 06268

STATE PROCEDURES REGARDING MEDICATIONS:

Campers must surrender all medication, EVEN OVER-THE-COUNTER MEDICATION (i.e. Tylenol, Advil, etc) to our Medical Staff at check-in, to be placed in a locked medical box for the duration of the camp. Campers may self-administer medications when needed with documented parental and authorized prescriber permission. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber or dentist's name and date of the original prescription. Over-the-counter medication must be in the original container and labeled with the child's name.

Date:______________

I hereby request that the following medication be self-administered by my daughter, ___________________________, for the camp week of ____________________.
(PLEASE PRINT CAMPERS NAME) (MONTH, DATE, YEAR)
I understand that I must supply the youth camp with the prescribed medication in its original container and properly labeled by a physician/pharmacist. Over the counter medication shall be labeled with the child's name by the Parent/Guardian(s) at check-in.
I understand that this medication will be destroyed if not picked up within (1) week following the end of this session of camp.

Name of Medication:____
Times of Administration:____, ____, ____ Shall be administered from ___/___/___ to ___/___/___
Is this a controlled drug?__________

Authorized prescriber's or Dentist Name (PRINT):____________________ Phone #:______________

Street Address___________________________ City/Town___________________ State_______

Authorized Prescriber or Dentist Signature______________________________________

Parent/Guardian(s) Name (Printed):______________________________

Parent/Guardian(s) Signature:___________________________________

Relationship to child:__________________________________

Phone Number:____________________

Name of Child:__________________ Room #:______ Skill Group:________ Pharmacy Name________________ Prescription #_____________________

Medication Name:____

Date:__/__/__ Time:_____ AM/PM Dosage:_____ Strength:______ Trainer:______
Comments:____
____
____

Medication Name:____

Date:__/__/__ Time:_____ AM/PM Dosage:_____ Strength:______ Trainer:______
Comments:____
____
____

Medication Name:____

Date:__/__/__ Time:_____ AM/PM Dosage:_____ Strength:______ Trainer:______
Comments:____
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Medication Name:____

Date:__/__/__ Time:_____ AM/PM Dosage:_____ Strength:______ Trainer:______
Comments:____
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Medication Name:____

Date:__/__/__ Time:_____ AM/PM Dosage:_____ Strength:______ Trainer:______
Comments:____
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Medication Name:____

Date:__/__/__ Time:_____ AM/PM Dosage:_____ Strength:______ Trainer:______
Comments:____
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