PRN - As Needed Medication

CHILDS NAME _____ Age _____ Date _____

Name of Medication: _____ RX # _____

Strength _____ Dosage _____ Dispense at (time)_____

Reason for Medication:

_____

We cannot give this medication for any symptom other than those listed below. List all Symptoms for which this medication should be dispensed:

_____

_____

_____

_____

_____

Optional Comments or Side Effects we should be aware of:

_____

_____

_____

_____

_____

Physician's Name: _____Phone #_____

_____

Signature of Physician *Date*

I authorize the Camp Summerset Health Designees to give this medication to my child and confirm that at least one dose of this medication was given to my child at home.

_____*If checked, my child can self-administer this medication.*

_____

Parent/Guardian's Name (print)

_____

Parent/Guardian Signature *Date*

The medication must be in its original container bearing a pharmacy label which shows the patients name, the medication prescription number, date filled, prescribing physician's name, name of medication, directions for taking the medication. **Any changes to medications administered during camp sessions must be communicated to a Camp Director in writing using this form.**