

December 2012

Dear Parents/Guardians:

Thank you for enrolling your child/adult in camp this summer. You noted on your registration form that your child will be taking medication during the week of camp. We are asking parents/guardians to complete a Medication Permission Form for Dispensing along with medication envelopes for each day and time your child needs medication at camp.

The intent of this policy is to provide a smooth check in and reduce the risk of confusion while dispensing medication.

1. Fill out Medication – Permission Form for dispensing, please be as specific as possible with medication name, dispensing instruction, description of medication, possible side effects.
2. Package medications in enclosed envelopes for each time and each camp session. Use one envelope for each time of the day (i.e. lunch) that medication is to be administered. Seal the envelopes completely. If your child takes **liquid medicine**, you must supply Camp Red Leaf with a bottle & spoon or dispensing cup labeled with your child's name.
3. **Bring the medication envelopes or liquid medicine to the check in for the session the camper is signed up for. Medication cannot be dispensed at camp unless it is provided in a Camp Red Leaf envelope and a permission form is completed and signed.**
4. Please call me if you have any questions or if more medication envelopes are needed.
5. Please send us a copy of your insurance card.

Sincerely,

Erin N. Newport
Camp Red Leaf Director

JCYS Camp Red Leaf

26710 W. Nippersink Rd, Ingleside, IL 60041-0297

Phone: 847-740-5010 Fax: 847-740-5014



Medication Administration Form

Camper's Name: _____

Emergency Contact Phone Number: _____

****A PHYSICIAN'S SIGNATURE MUST BE INCLUDED ON THIS FORM****

Please check how the camper usually takes his/her medication? With drink In food Other _____

ALLERGIES: _____

Medications (Please print and include medication name and dosage to be given)		Su	M	T	W	Th	F
Breakfast (8:30am)							
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
Lunch (12:30pm)							
1.							
2.							
3.							
4.							
Dinner (5:30pm)							
1.							
2.							
3.							
4.							
5.							
Bedtime (8:30pm)							
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Physician's Name: _____ Physician's Phone: _____

Physician's Signature: _____ Date: _____