

Camper's Name (print legibly!) _____

Girl Scouts of the Sierra Nevada

PERMISSION AND RELEASE FOR THE ADMINISTRATION OF MEDICATION

For ALL prescription and over-the-counter medications.

All medications must be brought in the original container with the camper's name and address, the doctor's name and phone number, and complete directions for use on the container and put in a ziplock bag with this form.

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Medication:							
Dose:							
Times to give:							
Administered by:							
Medication:							
Dose:							
Times to give:							
Administered by:							
Medication:							
Dose:							
Times to give:							
Administered by:							

Medications administered by:
 Initials _____/Signature _____
 Initials _____/Signature _____
 Initials _____/Signature _____

I have listed the above medication dosage and administration instructions. I authorize the Girl Scouts of the Sierra Nevada camp health supervisor to administer the above listed medications to my child during her participation. I understand that GSSN is not liable for lost or damaged medical equipment.

Parent/Guardian _____ Date _____

My child uses an EpiPen and/or inhaler and:
 _____ has my permission to keep it with her at all times (initial), OR
 _____ it should be kept with her counselor at all time (initial), OR
 _____ it should be kept in the Health Hut (initial)



Girl Scouts.

THIS FORM MUST BE PRESENTED AT TIME OF CHECK-IN!

Camper's Name (print legibly!) _____

Girl Scouts of the Sierra Nevada

PERMISSION AND RELEASE FOR THE ADMINISTRATION OF OVER-THE-COUNTER MEDICATION

Common over-the-counter medications are stocked in the Health Hut and will be administered at the discretion of the health supervisor to your child as per the following approval. Indicate the amount, frequency, and for what complaint(s) the following over-the-counter medications may be given to your child.

Tylenol/Children's _____

Tylenol/Adult _____

Advil _____

Calamine Lotion _____

Caladryl Lotion _____

Benadryl/Children's _____

Benadryl/Adult _____

Neosporin _____

Pepto-Bismol _____

Other _____

Parent/Guardian _____ Date _____



Girl Scouts.

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