**CAMP KOINONIA MEDICATION FORM**

DO NOT MAIL THIS FORM – BRING DIRECTLY TO SPIRITUAL DIRECTOR  
This form must be completed for Teen Staff bringing medication to camp.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Camp Week: \_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact & Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician & Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All medications will be kept in a locked cabinet under the supervision of the Spiritual Director/designated Program Staff. Medications may not be kept in the teen staff cabins, with the exception of Inhalers, Epi-Pens, or other emergency medications. This form must be completed fully in order for Spiritual Director to administer the required medication.

* Prescription medication must be in the labeled original container by the pharmacist or prescriber.
* Please be specific with any variation or conditions associated with “as needed”.
* **Inhaler, EpiPen,** or other emergency med to camp may remain with teen staff, but still add to this list
* Nonprescription/over the counter medication (ie, allergy, pain relievers, vitamins, homeopathic) must be in the original container with the instructions for use.
* An adult must bring the medication to the camp and give the medication to the Spiritual Director upon arrival on Saturday

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| Please list all medications that your camper will bring to camp below. This includes over-the-counter and prescription medications. (Please write “as needed” under Time of Day if the medication is not required, ie, for headache) | | | | Camp staff to record when medication is administered: | | | | | | |
| Medication | Dosage | Reason | Time(s) of Day or Indicate “as needed” | S | S | M | T | W | TTh | F | |
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(Please copy this page as needed for additional medications.)

Parent/Guardian Authorization

I request authorized Camp Koinonia operator/staff to administer the medications above. I certify that I have legal authority to consent to medical treatment for the youth named above, including the administration of medication at the facility. I understand that at the end of the authorized period, an adult must pick up the medication, or it will be discarded. I authorize camp personnel to communicate with the prescriber as allowed by HIPAA. I confirm that, if the medication above is a prescription medication, the child has at some point taken the medication prior to attending camp.

**Parent/Guardian Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Phone #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_