Medication Assistance & Allergy Information Form

Name of Camper:_____

EpiPen: Yes No Location:_____

Allergy Specific

Allergen	Reaction Type (inhalation, contact, ingestion)	Symptoms (specific to child)
1.		
2.		
3.		
4.		

Allergy Specific Medications to be given, with instructions	
1.	
2.	
3.	
4.	

Specific Medication Assistance

Medication	Dosage Information (dates, time, amount, frequency)

Other Pertinent Information: _____

_____

_____

I give permission for the KidsCamp Staff at Grey Roots to administer the medication as specified and directed to the child listed above or in the event of an emergency (this includes the use of EpiPens).

I agree that it is my responsibility to bring the medication which shall be labeled with the name of the patient, the prescribing physician, the name of the medication, the dosage, frequency and duration of the medication. The request will expire on the last date stated above.

I understand that any staff person involved in these procedures is acting in the place of the child's guardian and not as a health professional.

_____

Parent/Legal Guardian Name

_____ _____

Parent/Legal Guardian Signature Date