



1055 Willeo Road
Roswell, GA 30075

Camp Office (770) 993-7975
Health Center (678) 507-1180
HealthCenter@highmeadows.org

Authorization for Camper to Carry Medication

Camper First and Last Name _____ Date of Birth _____

The above-named camper needs to carry the following prescribed emergency medication/medical supplies: _____ for anaphylaxis, asthma, diabetes, and/or seizures while on camp property/camp trips. The above-named camper has been instructed in, and demonstrates understanding of, the proper use of this medication. It is my professional opinion that the camper may be permitted to carry and self-administer this medication. I have provided the parent/legal guardian with the appropriate action plan.

Prescribing Physician First and Last Name

Prescribing Physician Signature

Practice Name and Phone Number

Date

I have been instructed in the proper use of the above-named medication/medical supplies, and fully understand how and when to use it. I will always carry the above-named medication/medical supplies with me, and will not allow another camper to handle or use it. I will notify the Camp Nurse of any complications/symptoms of my medical condition. I will tell the Nurse each time I use the above-named medication while on camp property/trips.

Camper First and Last Name

Camper Signature

Date

I hereby request that the above-named camper, over whom I have legal guardianship, be allowed to carry and use the above-named medication/medical supplies while on camp property/trips. I accept legal responsibility should the medication/medical supplies be lost, damaged or not immediately available, or given to/taken by another person other than the above-named camper. I understand that if this happens, the privilege of carrying the medication/medical supplies may be revoked.

I have read the Health Center policies as stated in the Family Guide. I will inform the Camp Nurse/ designated staff of any changes/complications to my child's medical condition, as well as any changes in treatment or medication, and submit a new form to reflect the changes.

The appropriate action plan and Authorization for Medication forms must be completed by the above-named camper's physician and returned to the Health Center along with this completed form. When possible, I will provide and bring 2 sets of the medication/medical supplies to the Health Center. 1 set will be carried by the above-named camper and the other set will be kept in the Health Center as a backup, after being processed by the Camp Nurse.

I hereby release High Meadows Camp and its employees and officials of any legal responsibility when supervising/assisting in this medication administration, and anything related to the above-named camper's possession and self-administration of the above-named medication/medical supplies.

Parent/Guardian First and Last Name

Parent/Guardian Signature

Date