



MEDICATION INFORMATION

Please Read Carefully

*MEDICATION includes prescription, non-prescription, vitamins and herbal medication. It includes those taken by mouth, inhaled, injected, suppositories or application (including drops in eyes or nose or creams on skin).

*Definition from MI State Guidelines for Administration of Medications to Pupils at School

In order for your child to receive ANY medication; prescription **or** non prescription while at camp, a MEDICATION PERMISSION FORM must be thoroughly completed and signed by BOTH the parent/guardian **and** child's physician. Please include exact medication name and dosage. This form can be faxed directly to the camp from your physician's office. FAX NO: (269-721-1071)

- All medication must be sent in the original container. This includes inhalers and unit dose medications (i.e. Albuterol, Proventil, and Asmanex, Nasonex etc).
- No pill boxes-original containers only.
- Original pharmacy label must be on the prescription medications with your child's name.
- Medication cannot be given if it is expired.
- Medication cannot be combined in one bottle such as putting 5mg and 10mg pill in the same bottle or two different medications in one bottle. No daily pill boxes.
- If pills need to be cut, please cut them ahead of time. We cannot alter medication.

If your child starts a new prescription medication after the Medication form is completed, another Medication Permission Form is available on line at clearlakecamp.org under Forms.

NOTE: Our staff will carry children's emergency medication. If this is not acceptable, then you must also provide an Emergency Care Plan written by the physician and parents. (The Revised School Code Section 380.1179) (Link to code: <http://legislature.mi.gov/doc.aspx?mcl-380-1179>)

For a child who is a diabetic, or who has severe asthma and uses a nebulizer, severe food allergy or has other critical health issues; a written Health Care Plan provided by the Doctor is required. Also, for the best care of your child, please contact camp ahead of time to discuss this plan. Sample health care plans may be found on line at <http://www.pacer.org/health/samplehealthplans.asp>

If you have any questions regarding medications please call the OEC HEALTH OFFICER prior to your child arriving at camp at 269-721-8161 between 8:00AM and 4:00 PM, Tues – Thurs.



Battle Creek Public Schools
 Outdoor Education Center
 10160 South M-37 HWY
 Dowling, MI 49050
 269-721-8161 FAX: 269-721-1071

MEDICATION PERMISSION FORM

For ANY medication (Including: Prescription drugs, Over-the-counter drugs, herbal supplements, vitamins, cough drops)

Student Name: _____ Grade: _____

Date of Birth: _____ School: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I request that (My Child) _____ receive the listed medications at camp. I understand that the medication will be administered exactly as per the directions of the prescribing physician.

Parent/Guardian Signature: _____ Date: _____

Address: _____ Telephone: _____

Prescribing Physician: _____

Address: _____ Telephone: _____

TO BE COMPLETED BY PHYSICIAN:

Please include exact drug name and mg/ml/mcg (Dosage).

Typical camp med times are meal times- (B, L, D), 4:00pm and Bedtime.

Medication:

- (1) Name of medication: _____
 Dosage: _____ When given: _____
 Reason for Medication: _____
 Special instructions: _____
- (2) Name of medication: _____
 Dosage: _____ When given: _____
 Reason for Medication: _____
 Special instructions: _____
- (3) Name of Medication: _____
 Dosage: _____ When given: _____
 Reason for Medication: _____
 Special instructions: _____
- (4) Name of Medication: _____
 Dosage: _____ When given: _____
 Reason for Medication: _____
 Special instructions: _____
- (5) Name of Medication: _____
 Dosage: _____ When given: _____
 Reason for Medication: _____
 Special instructions: _____
- (6) Name of Medication: _____
 Dosage: _____ When given: _____
 Reason for Medication: _____
 Special instructions: _____

ORDERS MAY BE FAXED DIRECTLY TO OUR OFFICE AT 269-721-1071

If more space is needed, fill out and sign a second form. Please put an X through unused spaces.

Physician's Signature: _____