

The Salvation Army Camp Mihaska and Conference Center



Youth Summer Camps 2022

MEDICATION POLICY

If your child is bringing medication to camp, please read, complete the following, and upload to the parent portal.

1. Your child must continue all medications (i.e. prescription or over the counter), as ordered by the licensed prescribing physician, while at camp.
2. In order for your child to attend camp, the medication must be present and a completed Medication Administration Form must be on file at camp.
3. Each medication must be in its original container; having the name of the person to whom it was prescribed clearly marked on the label and contain the prescribing physician's name, prescription date, expiration date and name of the prescription.
4. All medication will be given according to the label directions unless otherwise specified in writing by the prescribing physician.
5. All medication will be kept in the Health Center and given out from the Health Center or another appropriate place based on activities. Medication is administered by the camp nurse or other appropriate health staff—except inhalers, which may be kept with the camper or counselor at the nurse's discretion.
6. DO NOT send non-prescription, over-the-counter drugs, creams, lotions, or other treatments with your child—unless prescribed by the licensed physician. We supply these items based on the Camp's standing orders.

Medication Administration Form

The following must be signed by prescribing Physician:

Camper Name: _____

Any camper (under 18 years of age) who needs medication dispensed at camp **MUST** have this form filled out and signed by the prescribing physician before any medication can be administered.

Use only one form for each prescription and have it completed by each prescribing physician. (PHOTOCOPY AS NEEDED.)

Name of Medication: _____ Dosage: _____ Frequency: _____

Duration: _____ Route: _____ Adverse Reaction: _____

Specific Conditions when a physician should be contacted or other instructions:

→ Prescribing Physician's Signature: _____

Signed and Stamped by Physician

Date

Phone: ()

Fax: ()