University of Kentucky
College of Agriculture, Food and Environment
Cooperative Extension Service

4-H Summer Camp Medication & Prescription Form 2017

Participant's Name: ________________________________ Age: ___ Weight:_________

Camp: ______________ County: ______________________ Cabin Number: ___________

For Office Use Only
Date:
____
Health Care Provider (HCP's Initials)
____

INSTRUCTIONS: The following **must be completed for each medication brought to camp** that is to be taken by your child during 4-H camp. Please list medications **in the order** in which they are to be taken. **This includes inhalers**. Fill in the name and dosage (as listed on the container) for each medication, along with any special instructions (take with food, etc.). Please place an ✓ in the appropriate Day/Time slot under the parent column for when medicine should be administered. Or check mark As Needed next to Dosage if appropriate. **PLEASE SEND ONLY THE NUMBER OF PILLS YOUR CHILD WILL NEED FOR THE CAMP SESSION IN THE ORIGINAL CONTAINER(S).** (HCP will initial as medication is given.)

PLEASE LIST any medications that should be kept with the participant all times (i.e. EpiPen, inhaler):

1. **Prescription Name:** ______________________________ Dosage: __________________ As Needed: (✓)_______

Special Instructions:

	Breakfast		Noon		Dinner		Bedtime		Other	
	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

2. **Prescription Name:** ______________________________ Dosage: __________________ As Needed: (✓)_______

Special Instructions:

	Breakfast		Noon		Dinner		Bedtime		Other	
	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP' Initials**
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

Parent Declaration: I, ____________________________, as the parent or legal guardian of__________________________, in the event that my directions differ from those on the original container, understand that I must obtain a note from the prescribing physician confirming the directions that should be followed in administering medications to my child. Furthermore, I understand that if there are any questions or concerns, I may be contacted at (H) ____________________ (Cell) ____________________

Cooperative Extension Service
Agriculture and Natural Resources
Family and Consumer Sciences
4-H Youth Development
Community and Economic Development

Educational programs of Kentucky Cooperative Extension serve all people regardless of economic or social status and will not discriminate on the basis of race, color, ethnic origin, national origin, creed, religion, political belief, sex, sexual orientation, gender identity, gender expression, pregnancy, marital status, genetic information, age, veteran status, or physical or mental disability. University of Kentucky, Kentucky State University, U.S. Department of Agriculture, and Kentucky Counties, Cooperating.

LEXINGTON, KY 40546

Disabilities accommodated with prior notification.

University of Kentucky
College of Agriculture, Food and Environment
Cooperative Extension Service

Participant Name: ____________________________________

3. Prescription Name: ____ Dosage: ________________________ As Needed: (✓)______

Special Instructions:

	Breakfast		Noon		Dinner		Bedtime		Other	
	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

4. Prescription Name: ____ Dosage: ________________________ As Needed: (✓)______

Special Instructions:

	Breakfast		Noon		Dinner		Bedtime		Other	
	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

5. Prescription Name: ____ Dosage: ________________________ As Needed: (✓)______

Special Instructions:

	Breakfast		Noon		Dinner		Bedtime		Other	
	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**	Parent (✓)	**HCP's Initials**
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

ALL MEDICATION MUST BE IN ORIGINAL CONTAINERS

Cooperative Extension Service
Agriculture and Natural Resources
Family and Consumer Sciences
4-H Youth Development
Community and Economic Development

Educational programs of Kentucky Cooperative Extension serve all people regardless of economic or social status and will not discriminate on the basis of race, color, ethnic origin, national origin, creed, religion, political belief, sex, sexual orientation, gender identity, gender expression, pregnancy, marital status, genetic information, age, veteran status, or physical or mental disability. University of Kentucky, Kentucky State University, U.S. Department of Agriculture, and Kentucky Counties, Cooperating.

LEXINGTON, KY 40546

Disabilities accommodated with prior notification.