

Camp Bishopswood Emergency Medication Form

Please fill out option A or B

***Please note.** The state of Maine requires an order for the medication and a note stating your child is trained and capable of self-administration **from your child's primary care physician** in order for your child to self-administer emergency medications.

A.

I have read and understand Camp Bishopswood's Emergency Medication Policy.

1. I **give permission** for my child, _____ to carry his/her emergency medication (such as rescue inhaler, Epi-pen, etc.) on his/her person to all camp activities, in the provided fanny pack or his/her personal pack at all times. I understand that it will be my child's responsibility to make sure he/she has the medication with him/her at all times. My child is trained to self-administer his/her medication and may self-administer the medication if needed. (Camp staff are Epi-pen trained and will assist if needed.) I further understand **that if my child is determined to be handling such medication irresponsibly or inappropriately by camp staff, the medication will be kept in the Great Hall medication closet** and will be readily available but may not be immediately available by reason of distance. (My child understands that all use of emergency medications must be reported to a staff member and recorded.)

Parent/guardian signature _____ date _____

Witness _____ date _____

B.

I have read and understand Camp Bishopswood's Emergency Medication Policy.

I **do not give permission** for my child, _____ to carry his/her emergency medication (such as rescue inhaler, Epi-pen, etc.) on his/her person to all camp activities. I understand that my child's emergency medication will be kept in the Great Hall medication closet and will be readily available but may not be immediately available by reason of distance.

Please circle appropriate options below

1. My child **is** trained to self-administer his/her medication and **may** self-administer under the direct supervision of a staff member. I understand that should my child be unable to self-administer, assistance will be provided by supervising staff.
2. My child **requires** staff assistance to administer emergency medication. (All use of emergency medications will be monitored and recorded.)

Parent/guardian signature _____ date _____

Witness _____ date _____