Summer Camp at Civitan
MEDICATION LIST

Applicant's Name____

Please attach a copy of Insurance/Medicaid/Medicare Card.

Is the applicant covered by hospitalization insurance? ☐YES ☐ NO

Carrier ____

Policy or Group No.___________________________Medicaid/Medicare#___________________________________

Camper's Physician or Healthcare Facility: ____

Phone #:____________________________________

MEDICATIONS: *Must be brought in* ***Original Container****(s) or* ***Bubble Pack****(s)* ***and include AUTHORIZATIONS for each medication! We cannot accept medication we do not have a script from the doctor even for over the counter medications. It is recommended that the camper bring only enough medication as needed for the session(s) attended.***

PLEASE LIST ALL MEDICATIONS CAMPER IS TAKING AND INDICATE PRESCRIBING PHYSICIAN
THIS DOES NOT REPLACE AN AUTHORIZATION.

MEDICATION	DOSAGE	PRESCRIBING PHYSICIAN

Medication Authorization Form

A SEPARATE FORM MUST BE COMPLETED FOR EACH MEDICATION!

Please note: medications must be delivered as it was originally dispensed from the pharmacy

Participants Name: ______________________ Site: **Summer Camp at Civitan 2020**

The following is to be completed by the **PHYSICIAN OR DESIGNEE:**

Name of medication: ______________________ **Dosage:** ____________

Route: ______________________ (circle one): **DAILY** **PRN**

If given daily-specify time(s): ____________

If given PRN - *describe:*

Indications: ______________________ *Frequency*: ______________________

Reason for Medication: ______________________

Possible Side Effects: ______________________

If side effects, occur notify Doctor: ☐ YES ☐ NO Any restrictions on activity(s)? ☐ YES ☐ NO

If restrictions, what? ______________________

What instructions should be followed if the medication is omitted in error and discovered? ____________

Less than 8 hours after scheduled dose? ________ More than 8 hours after scheduled dose? ________

When should the patient be re-evaluated? ________ Is this a controlled substance? ☐ YES ☐ NO

Physician's Signature: ______________________ Date: ____________

Print Name: ______________________ Address: ______________________

Telephone: ______________ Fax: ______________

Participant, Care-provider and/or Legal Guardian should complete this section…

I will be responsible for bringing the prescription drugs to Eggleston in the original labeled container from the pharmacist. I also understand that I am responsible for maintaining a sufficient quantity of the medication at Eggleston to avoid any interruptions in the physician's orders. Failure to do this will result in termination of this authorization.

Participant Signature: ______________________ Date: ____________

Authorized Representative: ______________________ Date: ____________

Telephone Number: (Primary)______________________ (Secondary)______________________

Medications must be in their pre-packed bubble packs, *as received from the pharmacy*. This policy covers all prescription and non-prescription such as Tylenol. The label *must include* the participant's name, route, dosage, time to be administered, quantity and the prescribing physician's name.

(Call office for questions)