

Summer Swim Camp

Camper Medication, EpiPen® and Inhaler Administration

To be completed for any or all medications that will be brought to and administered at camp.

If no medications, this form is not required.

Please Read: Prescribed medications must include the pharmacy label with the Rx number, the name of the medication, dosage, directions for use, and the child or staff's name. Non-prescription medications must be in its original containers, clearly labeled with the child's or staff's name and directions for use. All medications must be kept with the Camp Director. Please complete the following information regarding the appropriate times and dosages of each medication your child or staff will receive at the Watertown Boys and Girls Club (attach additional forms if needed). Please sign at the bottom of the page.

Name of Medication (if Inhaler or EpiPen® complete below as well):		
Why is this medication taken?		
Days Taken (please circle) M T W Th F <input type="checkbox"/> As needed		
Times Taken (be specific) _____ AM PM Other _____ Dosage _____		
Are there any additional notes or instructions for this medication?		

Name of Medication (if Inhaler or EpiPen® complete below as well):		
Why is this medication taken?		
Days Taken (please circle) M T W Th F <input type="checkbox"/> As needed		
Times Taken (be specific) _____ AM PM Other _____ Dosage _____		
Are there any additional notes or instructions for this medication?		

Type of Inhaler:		
Location of Inhaler at camp (circle one)		
Designated secure storage	on camper's person	with camp counselor
Who can administer inhaler? (circle one)		
Qualified Personnel	Camper	

Type of <u>EpiPen®</u> :		
Location of <u>EpiPen®</u> at camp (circle one)		
Designated secure storage	on camper's person	with camp counselor
Who can administer <u>EpiPen®</u> ? (circle one)		
Qualified Personnel	Camper	

I hereby give permission to the Watertown Boys and Girls Club to administer the above medications to my child or staff member under eighteen years of age during his or her camp attendance.

Parent/Guardian Signature _____ Date: _____



2016 Immunization History

Each staff and camper participating in Summer Swim Camp is required to have a Certificate of Immunization on record, signed, and dated by a physician or designee. **We will accept forms generated directly from a physician's office or the completed form below.**

Camper or Staff Name _____ Birth Date _____

Address: _____
No Street City State Zip

Immunization History: Please record date (month and year) of immunizations and recent boosters.

Vaccine:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP/DTaP/DT						
Td (tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
TB Mantoux Test		Result:	(circle one)	Positive	Negative	
Haemophilus influenza B						
Hepatitis B						
Varicella (chicken pox)						

Licensed Physician's Signature: _____

Please Print Physician's Name: _____

Date of Examination: _____