V. Wilson Freeland, Director
Karyn Molines, Division Chief

CALVERT COUNTY
DEPARTMENT OF GENERAL SERVICES
NATURAL RESOURCES DIVISION

Courthouse, 175 Main Street
Prince Frederick, Maryland 20678
410-535-5327

MEDICATION RELEASE WAIVER

Child's Name: _____

Does the child require prescription medication during program hours?
Yes: ____ No: ____

If YES, parent or guardian complete the following:

I, _____, the parent/guardian of _____
(Print parent name) (Print child's name)

hereby request that identified members of the program staff be caretakers of medication and administrators of prescribed medication for the child named above and as prescribed by my physician.

_____ _____
Physician's Name Physician's Phone Number

I understand that members of the program staff will be instructed to take any medication from the child upon arrival at the camp and secure it in a safe location.

I understand that at a prescribed time, a staff member will retrieve the medication and hand it to the child in the container. The staff member will then watch the child take the medication.

I understand the Authorization for Prescription Medication Form must be fill out completely and signed by the child's doctor before the start of camp.

I also understand the staff who administers this medication are medically untrained. I hereby state, without reservation that I will not hold the Calvert County Natural Resources Division, or any of their employees and volunteers liable for any harm or injury which may be incurred by the camper in connection with this medical assistance, or damage/loss of medical equipment.

_____ _____
Signature of Parent/Guardian Date

AUTHORIZATION FOR PRESCRIPTION MEDICATION

Does the child require prescription medication during program hours? Yes: ____ No: ____
If YES, child's physician *MUST* complete the following:

Child's Name: _____

a.) Condition: _____

Medication: _____

Dosage / Schedule: _____

Special Instructions: _____

Side Effects / Toxic Effects: _____

b.) Condition: _____

Medication: _____

Dosage / Schedule: _____

Special Instructions: _____

Side Effects / Toxic Effects: _____

Only those medications prescribed and listed by the physician will be accepted. Medications must be in the original pharmaceutical container and labeled with the camper's name, name of medication, dosage, schedule, prescription number, date filled and prescribing physician's name.

Date of Order: _____ Duration of Order: _____
(If duration is less than current camp program, renewal of order may be necessary.)

I hereby authorize the program staff to dispense these medications as prescribed.

_____ _____
Printed Name of Physician Phone Number

_____ _____
Signature of Physician Date

OFFICIAL USE ONLY:
DATE RECEIVED: _____*STAFF INITIALS:* _____
Program _____*LOCATION* _____
Program _____*LOCATION* _____
Program _____*LOCATION* _____