

**Part I-Authorization to Administer Prescribed Medication to a student while in the “TRY-IT” Program**

\_\_\_\_\_  
Student’s Name (Last, First, MI)

\_\_\_\_\_  
Student’s School

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Student’s Birth date

**Prescription Medications** – Please check one.

\_\_\_\_\_ My child does not require any prescription medication while at camp.

\_\_\_\_\_ My child requires the following prescription medication while at camp.

***I have provided the medication, in its original container, for my child for storage and dispensing while my child is participating in the TRY-IT! camp. If the administration instructions for the medication have changed from those listed on the medication container, instructions which are signed by the prescribing physician must be provided to ensure proper administration of the medication.***

Please provide the information on all medications prescribed by your child’s physician in the spaces below:

Medication Name	
Strength	
Quantity sent to camp	
Storage (room temp, refrigerate, other)	
Reason for Medication	
Comments:	

**No medications (prescription or non-prescription) are to be in the possession of the individual campers; except medications required on an emergent basis, such as an Epi-pen, rescue inhaler, etc.**

**\*\*\*\*Failure to complete this form will disqualify your child from participation in the program.**

## Part II Use of Non-Prescription Medication

Sometimes minor illness can occur while a child is at camp. While we always attempt to call a child's parent or guardian in the event of a minor illness, **non-prescription medication** can be administered with written permission of the parent(s)/guardian (s).

I give my permission to administer:	Benadryl	Yes	No
	Advil	Yes	No
	Tylenol	Yes	No
	Pepto Bismol	Yes	No
	Chloraseptic Spray	Yes	No
	*Other _____	Yes	No
	_____	Yes	No

\*To the Parent/Guardian: Please indicate any other non-prescription medication that you normally administer to your child.

**Please list any allergies to:**

Medication: \_\_\_\_\_

Food: \_\_\_\_\_

Other allergies (for example, pollen, pets, insects): \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**“TRY-IT” Program**

\_\_\_\_\_  
Student's Name (Last, First, MI)

**\*\*\*\*Failure to complete this form will disqualify your child from participation in the program.**

**Part III-Medical History and Shot Records**

\_\_\_\_\_  
**Student's Name (Last, First, MI)**

Has the student been immunized/vaccinated for the following:

	Yes	No	Date
Measles, Mumps, Rubella (MMR)**	_____	_____	_____
Chicken Pox	_____	_____	_____
Tetanus Booster	_____	_____	_____

\*\*Student should have his/her measles vaccination before coming to the "TRY-IT" Summer Program, if he/she has not received a MMR **booster** during adolescence.

_____ <b>Physician's Signature</b>	_____ <b>Date</b>
_____	
_____	
_____	
<b>Address</b>	
(____) _____ <b>Telephone Number</b>	(____) _____ <b>Fax Number (if available)</b>

**This information may be faxed to us from your physician if you give your physician permission to do so. The TRY-IT! fax number is 859-323-9747**

**\*\*\*\*Failure to complete this form will disqualify your child from participation in the program.**