

COMMUNITY ART CENTER OF TOWSON UNIVERSITY
SUMMER ART CAMP

Authorization for Prescription/Non-Prescription Medication

Child's Name: _____ Today's Date: _____

- Prescription medication must be in its original pharmaceutical container with legible label including child's name, medication dosage and schedule.
- Only the exact amount of prescription medication should be delivered to the program. All measuring utensils used for administering medication must be labeled with child's name and brought in with the medication.
- Non-Prescription medication must be in the original container with the child's name, dosage and schedule placed on the front of the container.
- Medication must be collected one week after the program ends or the Camp Director will dispose of the medication.

Physician Authorization for Prescription and Non-Prescription Medication

Condition: _____

Medication: _____

Dosage and schedule during program hours: _____

Special instructions: _____

Side effects: _____

Duration of Order (*not to exceed current program*): _____

Asthma Inhaler

Asthma Inhaler Name of asthma inhaler medication #1: _____

Instructions: _____

Asthma Inhaler Name of asthma inhaler medication #2: _____

Instructions: _____

Epinephrine Injection

Give the injection indicated below immediately after report of exposure to: _____

Epi-pen (*given in premeasured dose of 0.3 mg epinephrine 1:1000 aqueous solution or 0.3 cc.*)

Epi-pen Jr. (*given in premeasured dose of 0.15 mg epinephrine 1:2000 aqueous solution or 0.3 cc.*)

Repeat dose of epinephrine in 15 minutes, if the rescue squad has not arrived.

Authorization for the Child or Teen to Carry and Self-Administer Medication

- The above named child may carry this medication with him/her during camp hours. He/she has received adequate information on how and when to use this medication, and I believe he/she can safely carry and self-administer it.

Physician Signature: _____

Date: ____ / ____ / ____

**III. Parent Authorization
for Prescription Medication**

PARENT AUTHORIZATION FOR PRESCRIPTION AND NON-PRESCRIPTION MEDICATION

Check each box that applies:

- I authorize my son/daughter/ward to take the medication as directed by his/her physician.
- I authorize my son/daughter/ward to carry and self-administer medication during program hours as directed by his/her physician.

I agree to release, indemnify and hold harmless Towson University, its agents and employees, from all liability from this authorization.

Parent Name (*print*): _____

Phone: _____

Parent/Guardian Signature: _____

Date: ____ / ____ / ____