mountain harmony camp
Region 12 Sweet Adelines International

for camp use only:

MEDICATION AUTHORIZATION FORM

Camp Dates: Fri., Nov. 21, 2025 – Sun., Nov. 23, 2025

To be completed by parent:

Child's Name: _____ Date of Birth: _____ Weight:_____

As the parent/guardian of the above-named child under age 18 I have read and complied with the following Mountain Harmony Camp rules for administering medication while at camp.

- The medication must be in its original container, with a legible label from the pharmacy, indicating the child's name, date, name of medication, expiration date, dosage, time and number of days medication is to be given, the doctor/nurse practitioners name, pharmacy name and telephone number.
- Over the counter medications must also be in their original containers and labeled with child's name
- Any medication samples must be accompanied by a doctor's written prescription.
- Medications are to be given only to the child indicated on the label (twins / siblings cannot share)
- Label constitutes the physicians/nurse practitioner's order.

Please initial the following if your child **must carry** her own emergency medication:

For children with Asthma: _____ As the parent/guardian of this child, I acknowledge that my child is responsible for, and competent in the appropriate use of, her prescribed asthma inhaler. I authorize my child to possess/carry her own prescribed asthma inhaler while at camp. I have provided a second inhaler to the Camp Nurse in case of loss or other emergency.

For children with EpiPen/Twinject/Auto Injector:_____ As the parent/guardian of this child, I acknowledge that my child is responsible for, and competent in the appropriate use of, her prescribed Epinephrine Auto-Injector. I authorize my child to possess/carry her own prescribed injector while at camp. I understand the Camp Nurse, or other designated adult, will immediately request assistance from an emergency medical service provider if this medication is administered. I have provided a backup dose of this medication to the Camp Nurse in case of loss or other emergency.

As the parent/guardian of the above-named child, I give permission for the designated Camp Medical Administrator to administer the prescribed, or non-prescribed, medication(s) listed below to my child. The undersigned agrees not to file or make any claim for negligence in connection with the administration or non-administration of this medicine(s) and further agrees to hold them harmless from any liability incurred as a result of the administration or non-administration of any medicines.

Name of Parent/Guardian (please print) _____

Signature of Parent/Guardian: _____ Date:_____

Primary Emergency Phone: _____ Secondary Emergency Phone: _____

LIST ALL MEDICATIONS HERE

Medication Name	Treatment of:	Mg / Type Ex: 100 mg Tablet	Dosage / Time