CAMP KEEP
Kern Environmental Education Program
A PROGRAM ADMINISTERED BY THE OFFICE OF JOHN G. MENDIBURU, Ed.D., KERN COUNTY SUPERINTENDENT OF SCHOOLS

KEEP STUDENT MEDICATION FORM

If you are sending any medication with your child, please read carefully.

1. KEEP Student Medication Form needs to be completed and signed by **both** physician and guardian **for each medication** being sent.
    - Send prescriptions and/or over-the-counter medications that your student takes daily.
    - Send "as needed" medications they are likely to need (e.g. inhaler, body aches, motion sickness, migraine, allergy, etc.)
2. Please do not send medications your student can do without. Camp KEEP maintains a supply of common over-the-counter medications for unexpected emergencies that you can approve on page 2 of their registration form.
3. All medications brought to camp must be turned into your child's school before departure.
4. Students are not allowed to carry medications. Medications will be locked in the first-aid room. Emergency medications (such as inhalers) will be carried by staff on every hike.
5. KEEP staff will administer oral or topical medications per physician instructions. KEEP staff will **NOT** conduct advanced medical procedures (e.g. suppositories, injections, etc.)

If your child has any of the following conditions, they also need a Physician Authorization Form.

Notify your child's teacher immediately. A medical shadow will likely be needed.

- Medications requiring suppositories or injections
- Diabetes
- Severe food allergy requiring epinephrine
- Severe bee sting reaction requiring epinephrine
- Severe asthma requiring daily breathing machine (nebulizer)
- Respiratory restrictions limiting activity
- Mobility limitations
- Seizures
- Recent hospitalizations or surgery
- Other serious physical or mental health conditions

KEEP Student Medication and Physician Authorization for can be found at **www.campkeep.org**.

KEEP STUDENT MEDICATION FORM

Student: _____ Date of Attendance: _____

School: _____ Teacher: _____

MEDICATION #1

Name of Medicine _____ Dosage (tabs, tsp., puffs, etc.) _____

Strength (mg., ml., etc.) _____ Frequency (hours apart, etc.) _____

SCHEDULE OF ADMINISTRATION:

❑ Daily (indicate times below) **OR** ❑ As needed (PRN) (Under what conditions?) _____

❑ 7:30AM Breakfast ❑ 12PM Lunch ❑ 3:30PM Snack ❑ 5:30PM Dinner ❑ 8PM Bed

(DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____

Comments: _____

➡ **Physician's Signature:** _____ **phone #:** _____

➡ **Parent/Guardian Signature:** _____ **phone #:** _____

MEDICATION #2

Name of Medicine _____ Dosage (tabs, tsp., puffs, etc.) _____

Strength (mg., ml., etc.) _____ Frequency (hours apart, etc.) _____

SCHEDULE OF ADMINISTRATION:

❑ Daily (indicate times below) **OR** ❑ As needed (PRN) (Under what conditions?) _____

❑ 7:30AM Breakfast ❑ 12PM Lunch ❑ 3:30PM Snack ❑ 5:30PM Dinner ❑ 8PM Bed

(DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____

Comments: _____

➡ **Physician's Signature:** _____ **phone #:** _____

➡ **Parent/Guardian Signature:** _____ **phone #:** _____

MEDICATION #3

Name of Medicine _____ Dosage (tabs, tsp., puffs, etc.) _____

Strength (mg., ml., etc.) _____ Frequency (hours apart, etc.) _____

SCHEDULE OF ADMINISTRATION:

❑ Daily (indicate times below) **OR** ❑ As needed (PRN) (Under what conditions?) _____

❑ 7:30AM Breakfast ❑ 12PM Lunch ❑ 3:30PM Snack ❑ 5:30PM Dinner ❑ 8PM Bed

(DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____

Comments: _____

➡ **Physician's Signature:** _____ **phone #:** _____

➡ **Parent/Guardian Signature:** _____ **phone #:** _____

SIGN FOR EACH MEDICATION. COPY THIS FORM IF NEEDED.