



Արարատ ճամբար / CAMP ARARAT – Medical Release Form

This Administration of Non-Prescription and/or Prescription Medication Authorization Form will go directly to Camp Ararat Nurse along with a well labeled zip lock bag with ALL your child's prescription and non-prescription medication.

THIS DOCUMENT MUST BE PRESENTED TO CAMP ARARAT ON REGISTRATION MORNING (Please print clearly)

Last Name: _____ First Name: _____ Date of Birth: ____ / ____ / ____ Age: ____

Father's Name: _____ Res. Tel. # _____ Cell # _____

Mother's Name: _____ Res. Tel. # _____ Cell # _____

Emergency Contact Person: _____ Res. Tel. # _____ Cell # _____

Health Card #: _____ Family Physician: _____ Physician Tel. #: _____

Date of last complete medical examination: ____ / ____ / ____ Date of last tetanus immunization: ____ / ____ / ____

Does your child wear/carry: Medical bracelet? ____ Neck chain? ____ Alert card? ____ Eyeglasses? ____ Contact lenses? ____

NB: Allergens are extreme in the wilderness so please remember to *include all* preferred allergy/respiratory meds, while foot injuries are most frequent due to the type of walking required so include good running shoes or hiking sandals.

(A) ADMINISTERING OF NON-PRESCRIPTION MEDICATION (eg. Tylenol, Topical ointments, Anti-Histamines, Polysporin, etc...) Although basic first aid treatment medications containing Drug Identification Numbers such as those referenced above do not require Medical Directives signed by a physician, this form confirms our/my authorization for the Camp Ararat authorized health personnel to administer, as required, first aid treatment requiring non-prescription medications containing a drug identification number such as those referenced.

List ALL medications sent with camper: *eg. Preferred Allergy meds, puffers, Tylenol, Advil* _____

(B) ADMINISTERING OF PRESCRIPTION MEDICATION (IF APPLICABLE)

1- Name of Prescribed Medication: _____ Purpose: _____

Instructions per physician/pharmacist and cautions: _____

2- Name of Prescribed Medication: _____ Purpose: _____

Instructions per physician/pharmacist and cautions: _____

3- Name of Prescribed Medication: _____ Purpose: _____

Instructions per physician/pharmacist and cautions: _____

(C) LISTING OF all KNOWN medical conditions, allergies or sensitivities (Provide details of all known symptoms):

AUTHORIZATION AND RELEASE: I, the Parent/Guardian of _____, hereby authorize the Camp Ararat authorized health personnel to administer the above **non-prescribed and/or prescribed medication** to be administered on my child in accordance with the procedure and instructions outlined above and access to personal health information to the authorized personnel. At all times it remains the responsibility of the parent to ensure that clear instructions from a medical practitioner relating to the use of the medication are provided. Camp Ararat assumes NO LIABILITY unless caused by willful negligence or misconduct of Camp Ararat or its employees. I hereby acknowledge that I have read and fully understand the terms set out herein.

Parent/Guardian Signature _____ Date: _____