



V. Wilson Freeland, Director
Karyn Molines, Division Chief

**CALVERT COUNTY
DEPARTMENT OF GENERAL SERVICES
NATURAL RESOURCES DIVISION**

Courthouse, 175 Main Street
Prince Frederick, Maryland 20678
410-535-5327

Board of Commissioners
Mike Hart
Tom Hejl
Pat Nutter
Evan K. Slaughenhaupt Jr.
Steven R. Weems

MEDICATION RELEASE WAIVER

Child's Name: _____

Does the child require prescription medication during summer camp hours?

Yes: ___ No: ___

If YES, parent or guardian complete the following:

I, _____, the parent/guardian of _____
(Print parent name) (Print campers name)

hereby request that identified members of the camp staff be caretakers of medication and administrators of prescribed medication for the camper named above and as prescribed by my physician.

Physician's Name Physician's Phone Number

I understand that members of the camp staff will be instructed to take any medication from the camper upon arrival at the camp and secure it in a safe location.

I understand that at a prescribed time, a staff member will retrieve the medication and hand it to the camper in the container. The staff member will then watch the camper take the medication.

I understand the Authorization for Prescription Medication Form must be fill out completely and signed by the camper's doctor before the start of camp.

I also understand the staff who administers this medication are medically untrained. I hereby state, without reservation that I will not hold the Calvert County Natural Resources Division, or any of their employees and volunteers liable for any harm or injury which may be incurred by the camper in connection with this medical assistance, or damage/loss of medical equipment.

Signature of Parent/Guardian Date

OFFICIAL USE ONLY:
DATE RECEIVED: _____ STAFF INITIALS: _____

CAMP _____ LOCATION _____
CAMP _____ LOCATION _____
CAMP _____ LOCATION _____



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AUTHORIZATION FOR PRESCRIPTION MEDICATION

**Does the child require prescription medication during summer camp hours? Yes: _____ No: _____
If YES, child's physician *MUST* complete the following:**

Child's Name: _____

a.) Condition: _____

Medication: _____

Dosage / Schedule: _____

Special Instructions: _____

Side Effects / Toxic Effects: _____

b.) Condition: _____

Medication: _____

Dosage / Schedule: _____

Special Instructions: _____

Side Effects / Toxic Effects: _____

Only those medications prescribed and listed by the physician will be accepted. Medications must be in the original pharmaceutical container and labeled with the camper's name, name of medication, dosage, schedule, prescription number, date filled and prescribing physician's name.

Date of Order: _____ Duration of Order: _____

(If duration is less than current camp program, renewal of order may be necessary.)

I hereby authorize the camp staff to dispense these medications as prescribed.

Printed Name of Physician

Phone Number

Signature of Physician

Date

OFFICIAL USE ONLY:

DATE RECEIVED: _____ **STAFF INITIALS:** _____

CAMP _____ **LOCATION** _____

CAMP _____ **LOCATION** _____

CAMP _____ **LOCATION** _____

