



80 Carby St, Westwood, MA 02090 Tel (781) 326-1770

2009 Membership Beach Epi-Pen / Inhaler Form

Fax (781) 326-0676 www.HaleReservation.org

Camper's Name: _____

Dates Attending Program: _____

For child with prescribed INHALERS

**Location of where inhaler is kept
(you must choose an option from this box)**

- _____ I request that my child's inhaler(s)
Medication name: _____
be kept in the guard shack *(or area designated as the secure medicine storage location)*
- _____ I request that my child's inhaler(s)
Medication name: _____
be kept on my child's person at all times while at camp.
- _____ I request that my child's inhaler(s)
Medication name: _____
be kept with my child's counselor at all times while at camp.

For child with prescribed EPI-PENS

**Location of where *Epi-Pen* or *Epi-Pen Jr* is kept
(you must choose an option from this box)**

- _____ I request that my child's *Epi-Pen* or *Epi-Pen Jr*
Medication name: _____
be kept in the guard shack *(or area designated as the secure medicine storage location)*
- _____ I request that my child's *Epi-Pen* or *Epi-Pen Jr*
Medication name: _____
be kept on my child's person at all times while at camp.
- _____ I request that my child's *Epi-Pen* or *Epi-Pen Jr*
Medication name: _____
be kept with my child's counselor at all times while at camp.

**Person who can administer inhaler
(you must choose an option from this box)**

- _____ I request that my child's inhaler(s)
Medication name: _____
be administered by qualified personnel as prescribed.
- _____ I request that my child's inhaler(s)
Medication name: _____
be self administered by my child.

**Person who can administer *Epi-Pen* or *Epi-Pen Jr*
(you must choose an option from this box)**

- _____ I request that my child's *Epi-Pen* or *Epi-Pen Jr*
Medication name: _____
be administered by qualified personnel as prescribed.
- _____ I request that my child's *Epi-Pen* or *Epi-Pen Jr*
Medication name: _____
be self administered by my child.

IMPORTANT: Please read the following if your child is capable of self-administration of inhaler or epi pen. If I request that my child's inhaler or epi-pen be self administered by my child then **I certify that my child is capable of proper self-administration of medication and understand that my child's physician has given consent for my child to self-administer this medication.** I understand that if my child is using this medication unsafely, irresponsibly or fails to keep it out of the reach of other campers, the child will be taken (with the medication) to the guard shack immediately and a call to the parent/guardian will be placed. I understand that Hale Reservation and/or Membership Beach are **not** responsible for replacement of this medication if lost, stolen or improperly discharged. If my child's medication requires replacement for any reason, I agree to bring such replacement to Hale Reservation or Membership Beach immediately.

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Printed Name: _____

Beach Director's Initials: _____



**2009 Membership Beach
Medication Administration Form**

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Camper's Name: _____

Dates Attending Program: _____

For safety and accountability, your child's medication must be kept at the Guard Shack. **Prescribed medications must be accompanied by a pharmacy label containing the Rx number, the name of the medication, the dosage, directions for administration, and the child's name. All non-prescription medication must be in its original containers, clearly labeled with the child's name, and directions for its use.** Any non-prescription medications must also be accompanied by a doctor's prescription.

I hereby give permission for Hale Reservation to administer the following medication(s) to my child during his/her stay at Hale. **In the table below, please fill in the appropriate times and dosages of each medication for each day of your child's weeks at Hale.**

Medication:		Mon	Tues	Wed	Thur	Fri
	Morning					
	Noon					
What is this being administered for?	Afternoon					
	Other					
	As Needed					

Medication:		Mon	Tues	Wed	Thur	Fri
	Morning					
	Noon					
What is this being administered for?	Afternoon					
	Other					
	As Needed					

Medication:		Mon	Tues	Wed	Thur	Fri
	Morning					
	Noon					
What is this being administered for?	Afternoon					
	Other					
	As Needed					

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Printed Name: _____