

AUTHORIZATION FOR ADMINISTRATION OF SEVERE ALLERGY OR PRESCRIBED MEDICATIONS

I/we wish to enroll our child (your patient), _____, in the Jr Tracker and Wilderness Survival camp. We are requesting that they provide certain emergency care for the prevention of anaphylaxis if our child comes into contact with a certain allergen(s), as described below. Please complete Part I of this form. This record will remain on file at Amethyst Retreat Center during the course of the camp. If you need to provide further instruction or clarification, please document on a separate piece of paper, to serve as an addendum to this form.

PART I (TO BE COMPLETED BY A PHYSICIAN)

Child's Name

Child's Date of Birth

Allergies or Prescribed Medication:

Please provide a complete list of all events and/or substances that may trigger a severe allergic reaction (anaphylactic shock).

Bee Sting Other Insect Bites (Identify) _____

Food Allergies _____ Animal Fur (Identify) _____

Other Allergies (Identify) _____

Child will bring: Inhaler Diabetes Device Other Medication _____

Name of drug: _____ Dosage: _____ Frequency: _____

Time for Dosage: _____ Child will self-administer: Yes No

Route: _____ Date of Rx: _____

Please provide a complete list of all symptoms that indicate the child has come in contact with an allergen, that he/she requires emergency treatment, or is in need of the medication listed above.

Physician Name: _____

Address: _____

Phone Number: _____

Signature and Date: _____

PART II (TO BE COMPLETED BY PARENT(S)/GUARDIAN(S))

My child has the knowledge and skills to safely administer his/her medication, and is capable of self-administering his/her medication without assistance, and is responsible with the medical device/medication.

Parent/Guardian Signature and Date: _____

Parent/Guardian Signature and Date: _____

By signing below, I/we authorize Amethyst Retreat Center and its designated agents to follow the instructions as outlined in this form by my child's physician, including the administration of medication. I/we agree to update this form immediately if any changes take place. I further authorize Amethyst Retreat Center and its designated agents to contact my child's physician listed above.

Parent/Guardian Signature and Date: _____

Parent/Guardian Signature and Date: _____