

# **AUTHORIZATION FOR ADMINISTRATION OF SEVERE ALLERGY OR PRESCRIBED MEDICATIONS**

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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.

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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: \_\_\_\_\_