AUTHORIZATION FOR ADMINSTRATION OF SEVERE ALLERGY OR PRESCRIBED MEDICATIONS

PART I (TO BE COMPLETED BY A PHYSICIAN, IF APPLICABLE)

I/we wish to enroll our child (your patient), ______________________________, in the Jr Tracker & Wilderness Exploration 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.

____ _______________________________

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 COMLETED BY PARENT(S)/GUARDIAN(S), ONLY IF PART I IS INAPPLICABLE)

☐ 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: ____

SIGNATURES

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: ____