



**C- 6 Summer Resident Camp
Request for Assistance in the Administration of Medication
(Ohio Revised Code 3313.713)**

Part I – must be completed by a parent or guardian if any medicine is sent to Mohican School.

Part II (page 2) – must be completed by physician if physician-prescribed medicine is sent to Mohican School.

Part III (page 3) must be completed by a parent or guardian if non-prescription medicine is sent to Mohican School.

Part I

I/we hereby request and give permission to designated personnel to help in the self-administration of medication to my child.

Name of Student _____

Address _____

City _____ State ____ Zip Code _____

Grade _____

I/we am/are sending the medicine in the original container obtained from our physician or pharmacist.

I/we understand and acknowledge that designated personnel are under no obligation to render the assistance requested and that such assistance may be rendered by an employee of the district who is not medically trained. There may not be any adult available for injections, catheterization or other procedures for which specific training is necessary.

I/we hereby release Mohican School in the Out-of-Doors, Inc., its board of directors, board of trustees, officials and employees from any and all liability for damages or injury directly or indirectly resulting from the performance or failure of performance of the assistance requested.

I/we agree to submit a revised statement signed by my physician if any information provided in Part II should change before my/our student goes to Mohican School.

Signature of parent/guardian _____

Parent/Guardian Phone number _____ **Date** _____

Check where appropriate. Type of medication(s):

___ Physician prescribed – administered pursuant to instructions of physician. Part II is also completed.

___ Non-prescription. Part III is also completed.

Part II – must be completed by physician if physician-prescribed medicine is sent to Mohican School.

~~ Prescription medicine MUST be in the original container ~~

Name of camper _____

Name of physician _____

Physician Address _____

Physician Phone in case of emergency _____

Please list the name of drug, dosage and time or intervals dosage of drug is to be administered

IF GENERIC DRUG IS BEING SENT, BOTH NAMES ARE NECESSARY!

The name of this form must match the medicine sent.

Name of drug (& generic name)	Dosage	Frequency Times/day	Brkfst before/after	Lunch before/after	Supper before/after	Bedtime	Other

Date drug administration begins _____

Date drug administration ceases _____

Any severe adverse reactions that should be reported to the physician

Special instructions, if any, for administration or storage of the drug

Signature of physician _____

Date _____

Part III - must be completed by a parent or guardian if non-prescription medicine is sent to Mohican School.

I/we hereby request and give permission to designated personnel to help in the self-administration of non-prescription medication to my child.

I/we am/are sending the medicine in the original container obtained from our physician or pharmacist. (Please send only medicine that your child currently needs.)

I/we understand and acknowledge that designated personnel are under no obligation to render the assistance requested and that such assistance may be rendered by an employee of the district who is not medically trained.

I/we hereby release Mohican School in the Out-of-Doors, Inc., its board of directors, board of trustees, officials and employees from any and all liability for damages or injury directly or indirectly resulting from the performance or failure of performance of the assistance requested.

~~ Medicine MUST be in the original container ~~

Name of camper _____

Medication (non-prescription)	Dosage	Frequency Times/day	Brkfst before/after	Lunch before/after	Supper before/after	Bedtime	Other

Reason each medicine is needed _____

Possible reactions that, if they occur, should be reported to the parent _____

Date medicine administration begins _____ Date medicine administration ceases _____

Special instructions _____

Name of physician _____

Physician Address _____

Physician Phone in case of emergency _____

Signature of parent/guardian _____ Date _____