



**ARMY ATHLETIC ASSOCIATION  
SUMMER SPORTS CAMPS**

**DATE:** \_\_\_\_\_

**MEMORANDUM FOR:** Parents/Sponsor of: \_\_\_\_\_

**SUBJECT:** Camper use of Medication During Summer Sports Camps

The Certified Athletic Trainer accommodates parent requests for medication (including prescription, non-prescription, and over-the-counter) to be administered during the summer camp. According to *DoDEA Health Service Guide, DS Manual 2942.0*, camp personnel may administer medications when certain criteria are met.

In order for summer camp personnel to administer medications during camp, the attached form ***MUST*** be provided to the camp signed by the **parent** and a **physician**.

The medication **MUST** be in the original container, **properly labeled by the pharmacy or physician**. The label should indicate the name of the camper and the physician, the medication, dosage, and frequency. The date of the prescription must be a current date.

All medications will remain at the camp for the duration of the prescription and/or the end of camp. Any changes in the medication, dosage, or frequency will necessitate **a new form and a new, labeled container**.

Please email Jacquelyn McCann at [Jacqui.McCann@usma.edu](mailto:Jacqui.McCann@usma.edu) concerning health concerns. For other camp questions, please contact the respective summer sport camp your daughter or son will attend.

Jacquelyn McCann, ATC  
Associate Athletic Trainer  
United States Military Academy



**ARMY ATHLETIC ASSOCIATION  
SUMMER CAMPS**

*To be completed by physician*

**Name of Camper:** \_\_\_\_\_

**Diagnosis/Indication for Medication Administrations:** \_\_\_\_\_

**Medication:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_

**Time:** \_\_\_\_\_ **Route:** \_\_\_\_\_

**Duration:** \_\_\_\_\_

**Possible Side Effects:** \_\_\_\_\_

**Precautions/Restrictions:** \_\_\_\_\_

**Other Medications Taken:** \_\_\_\_\_

**Signature of Physician:**

\_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*\*\*\*

*To be completed by parent:*

I hereby give my permission for \_\_\_\_\_ to receive, from the Athletic Trainer, the above prescription at summer camp as ordered. I understand that it is my responsibility to furnish the camp with this medication. I give permission for the athletic trainer and health care providers at the medical treatment facility to exchange information about my child, the diagnosis for which this medication is prescribed, and my child's response to the medication.

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

Parent daytime phone number #1 \_\_\_\_\_, #2 \_\_\_\_\_

#3 \_\_\_\_\_

Parent e-mail address \_\_\_\_\_

**NOTE: The prescription medication must be brought to camp in the original container, properly labeled by the pharmacy or physician, stating the name of the student, the medication, the dosage, and current date. The medication will remain at camp for the duration of the prescription and/or the end of camp.**



ARMY ATHLETIC ASSOCIATION  
SUMMER SPORTS CAMP

## Permission for Camper to Retain Control of Medication

(All three sections must be completed and signed.)

### Section 1 (To be completed by physician)

Name of camper: \_\_\_\_\_ Age: \_\_\_\_\_ Camp: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Duration of Treatment: \_\_\_\_\_

Times of day/circumstances under which medication is to be given:

\_\_\_\_\_

Reason student must have possession of medication at all times:

\_\_\_\_\_

Expected results from using the medication:

\_\_\_\_\_

Expected time frame to achieve results following medication administration:

\_\_\_\_\_

What campers should do if the expected results are not obtained in the specified time frame:

\_\_\_\_\_

I have instructed the camper and the camper's parent in the proper use and method of administering this medication and the legal consequences of using the medication inconsistently with the prescription or of sharing the medication with anyone else. I have provided the camper and his/her parents with the following instructions regarding the symptoms of possible adverse reactions, contraindications, and what to do if camper experiences difficulty with or while taking medication:

\_\_\_\_\_

\_\_\_\_\_

The camper's medical condition is such that the camper must be in possession and control of the medication at all times and be free to administer the medication when needed. **In my opinion, the camper possesses sufficient maturity and responsibility to follow my instructions.**

Physician's signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

**Section 2 (To be completed by parent)**

<b>HOLD HARMLESS LETTER</b> (THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)		<b>DATE:</b>
<b>PRIVACY ACT STATEMENT</b> AUTHORITY: 44 USC 3101. PRINCIPLE PURPOSES: (1) To provide necessary information to authorized individuals to assist them in their administering of medications to your child in accordance with your instructions and the instructions of your child's physician; (2) To provide written assurance to said authorized individuals that they will not be held responsible for any harm or injury suffered as a result of the administering of medication in accordance with your instructions and the instructions of your child's physician. ROUTINE USES: This form will be included in your child's camp health record and will not be released outside DOD channels. DISCLOSURE: Voluntary. The information requested on this form is needed to insure the safe administering of medication to your child. Failure to provide the information may constitute grounds for refusal to provide the service requested by you.		
NAME OF CHILD	BIRTHDATE	NAME OF SCHOOL
<p>We, the parents of _____, wish to advise you that he/she is under the care of Dr. _____ for _____ and that the physician has furnished medications together with written instructions for administering the medications to alleviate this condition. The medication(s), physician's instructions, and times for administering the medication(s) are as follows</p> <div style="border: 1px solid black; padding: 5px; text-align: center;"><b>PHYSICIAN'S INSTRUCTION TO CAMP PERSONNEL</b></div> <p>Due to the nature of the medication(s) and/or the child's condition(s), it is necessary that the medication(s) listed below be administered during camp hours.</p>		
<u>Medication(s)</u>	<u>Physician's Instructions</u>	<u>Hour(s) for Administering</u>
Anticipated number of days the medication(s) must be given at camp (       )		
PHYSICIAN'S SIGNATURE	PHONE:	DATE:
<p>We are delivering to you the medication(s) and the physician's written instructions and request this medication be given to our child in accordance with the above instructions. We fully understand that you are under no obligation whatsoever to administer the medication but will only be doing so as our agent acting in our behalf specifically and solely for this purpose.</p> <p>We agree to hold you, the school, its offices, agents, and employees harmless in administering the medication(s) pursuant to the physician's written instructions and our instructions as to the times for administering the medication(s). We further agree to notify you promptly when it is no longer necessary to administer this medication</p>		
PARENT'S SIGNATURE	HOME PHONE	DUTY PHONE
	HOME ADDRESS	

Name of Parent (s): \_\_\_\_\_

Home phone: (\_\_\_\_\_) \_\_\_\_\_

Work phone: (\_\_\_\_\_) \_\_\_\_\_

Cell phone: (\_\_\_\_\_) \_\_\_\_\_

I have read the physician's statement and hereby consent to my child's retaining possession at all time of the above prescribed medication. I understand, and have informed my child, that any illegal use of the medication by the camper (including the use of the medicine inconsistent with the prescription or sharing the medication with another) will result in disciplinary action. **During camp hours my child has been instructed to take his/her medication as directed.**

Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*SECTION 3 (To be completed by student)**

I understand that I am required to retain possession and control of my prescribed medication in accordance with the terms set forth in Section 1 above. **I have been advised of my responsibility to use my medication only in strict accordance with the prescription.** I understand that any use of my medication inconsistent with the terms of my prescription is an illegal use, as is the sharing of my medication with a nother person. I agree to carry an pharmacy-labeled container of the medication, to keep a record of the times I use my medication, and to share the information with the athletic trainer/instructor/coach who will help evaluate and monitor the effects of my medication.

Student's signature: \_\_\_\_\_ Date: \_\_\_\_\_

*\*Guidance on the age of the student who signs this form needs to be obtained prior to its use.*