MEDICATION FORM

****Complete when camper has been approved****

www.horizonsct.org -*forms available on our website*

Horizons, Inc.
P. O. Box 323 South Windham, CT 06266
860-456-1032 fax: 860-456-4721

Camper's Name:_______________________________________DOB:_______________ Date:__________

Address:____
(STREET) (CITY) (STATE) (ZIP)

Medications will be dispensed at **B**-Breakfast(8:30am), **L**-Lunch(12:30pm), **D**-Dinner(6:00pm), **HS**-Hour of Sleep(8:00pm) unless otherwise specified

MEDICATION / STRENGTH OF EACH INDIVIDUAL PILL / ROUTE	DOSAGE AT EACH TIME / # OF PILLS	TIMES-USE B, L, D, HS IF POSSIBLE	SIGNATURE of PRESCRIBING PHYSICIAN-PLEASE SIGN EACH MEDICATION PRESCRIBED AND PRINT NAME	DATE

ALTERNATE FORMS ARE ACCEPTED ONLY IF SIGNED AND DATED. USE BACK for OTC MEDICATIONS.

MEDICATION FORM (pg. 2) NAME_____DOB_____

PLEASE NOTE ANY SPECIFIC INSTRUCTIONS REGARDING ADMINISTRATION OF MEDICATION

_____

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PLEASE NOTE ANY INSTRUCTIONS REGARDING POSSIBLE SIDE EFFECTS, DURATION OF TIME TO BE ADMINISTERED (i.e. 10 days, until finished, etc.)

_____

_____

Did this person bring any over-the-counter medications or treatments not prescribed? This includes Tylenol, Advil, cough syrup, vitamins, medicated creams such as Triple Antibiotic, Hydrocortisone, etc. Yes ___ No ___ Please list these below and describe when and how administered. **(Please note: Any item with a prescription label must be listed on the front of this form and include physician's signature. If your camper is under 18, you will need a physician's signature on the front of this form for over-the counter items.)**

Attention: This form will be returned to you if it is not filled out correctly and signed-please check it carefully. ***If changes are made in your camper's medication regimen once this form is completed, you are responsible for providing accurate updates.***

- ➔ **This form must include all medications and treatments prescribed to this camper- this includes lotions, inhalers, liquids, allergy medications, cold medications, temporarily prescribed meds. Sample medications will not be administered without the proper prescription label.**
- ➔ **Each medication listed must include accurate dosages, times and instructions.**
- ➔ **Each prescribed medication or treatment must be signed by the prescribing physician.**
- ➔ **Any changes in dose, time, frequency must be accompanied by a written physician's order or a new form.**
- ➔ **Any medication that has been added must be accompanied by a written physician's order or a new form.**
- ➔ **Any medication that has been discontinued must be accompanied by a written physician's order or a new form.**
- ➔ **Labels on medication containers must match this medication information form.**
- ➔ **No foreign prescriptions without proper labeling.**

IT IS THE PARENT/PROVIDER or GUARDIAN'S RESPONSIBILITY TO INSURE THAT ALL PRESCRIBING PHYSICIANS ARE AWARE OF ALL MEDICATIONS PRESCRIBED TO THIS CAMPER AND THAT NO CONTRA-INDICATIONS OR INTERACTIONS EXIST.

THIS FORM IS VALID FOR TWO YEARS IF ACCURATE
alternate forms will be accepted ONLY if signed and dated by the physician prescribing