

Medical Treatment and Medication Administration Consent Form

Completion of this form is REQUIRED prior to participation (105 CMR)

Camper: _____

Parent/Guardian: _____

Home Telephone: _____ Work Telephone: _____

Name of Physician: _____ Telephone: _____

Name of Insurance: _____ Policy #: _____

Alternative contact in the event that the Parent/Guardian cannot be contacted in the case of an emergency (injury/illness) involving the participant named above.

Name: _____ Relationship: _____ Telephone: _____

If your daughter will be under the age of 18 years while at Mount Holyoke College, it is policy to secure your consent for medical treatment and medication distribution, whether medication/treatment is self-administered or administered by designated camp staff.

All medications must be in original or separate medicine bottles and labeled with the camper's name. Prescription medication(s) must also include on the label doctor's name and phone number, medication name and dosage.

- No** medication brought to camp.
- Yes**, non-prescription/over the counter medications are being brought to camp. Non-prescription/over the counter medication can be self-administered. Please indicate the name of the medication(s), dosage, and reason for taking the medication:

If camper is **NOT** allowed to self-administer non-prescription/over the counter medications, sign here:

- Yes**, prescription medication(s) and/or medical device(s) are brought to camp. *Complete medication box below.*
- Yes**, I will self-administer the medication(s) and/or medical device(s). ***This is allowed if 14 years old or older. * ****
- Designated camp staff, i.e. nurse, athletic trainer, camp counselor, will administer the medication(s) and/or medical device(s). ***Mandatory for age 13 and under. * ****

*** However, a limited amount of medication for life threatening conditions may be carried by my daughter, i.e. allergy medications, bee sting kits, inhalers, insulin.*

Name of Medication and prescribing MD	Dosage	How is it taken, i.e. oral, injection	Time(s) of day medication is taken	Day(s)/Number of days medication is to be taken

Special Instructions:

By signing below, you are:

- Acknowledging that you have received the notice of Privacy Practices statement.
- Giving your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- Stating that you are aware of and accept the risk inherent in the program activity.
- Agreeing to hold harmless and indemnify the Board of Regents of Mount Holyoke College System, and Mount Holyoke College, their officers, agents and employees, from any and all liability, loss, damages, costs or expenses which are sustained, incurred, or required arising out of the actions of your dependent in the course of the camp/event.

Signature: _____ **Date:** _____