CITY OF NANAIMO
THE HARBOUR CITY
PARKS, RECREATION AND CULTURE

MEDICATION INFORMATION FORM

This form is designed to gather the necessary information on the prescribed medications that participants 0-15 years may bring with them to programs. If your child carries prescription medication, please complete the following form. **CAMP LEADERS WILL MONITOR AND ASSIST, BUT NOT ADMINISTER MEDICATIONS. NON-PHYSICIAN PRESCRIBED MEDICATIONS WILL NOT BE CARRIED BY LEADERS OR PARTICIPANTS AT CAMP.**

NAME OF PARTICIPANT: _____ BIRTHDATE: _____

DATES APPLICABLE: _____

	MEDICATION NAME	DOSAGE	REASON FOR MEDICATION
1.			
2.			
3.			
TIME(S) OF DAY TO BE ADMINISTERED:		ADDITIONAL NOTES:	

Depending on the type of medication, there are different procedures. **Please read carefully and initial next to the option that meets your child's circumstances.

	OPTION A:	My child carries a physician prescribed medication that is to be **self-administered** as required (e.g. asthma inhaler). I understand that my child will self-administer his/her medication on his/her own without the leader's assistance or monitoring.
	OPTION B:	My child carries a physician prescribed medication that is to be taken at a **scheduled** time. (e.g. anti-biotics) I understand that my child will self-administer the medication and the leader can monitor by watching and recording the child self-administering the medication. I agree to provide detailed directions including the dosage and time to be taken.

I,_____, the parent/guardian agree:

a) To meet with the leader on the first day and provide the completed form and show the leader the medication. Medication to be carried by the leader unless otherwise noted (e.g. asthma inhaler).
b) To send the medication the child needs for the day in the original container provided by a doctor or pharmacist.
c) Medication to be placed in a clearly identified, accessible and safe location. Location to be determined on a camp-specific basis.
d) To update the leaders on any changes in my child's conditions or medications.

PARENT/GUARDIAN NAME: _____

PARENT/GUARIAN SIGNATURE: _____ DATE SIGNED: _____

Please complete form and hand in to the program leader on the first day of program.

c:\users\tiffany.bossons\appdata\local\microsoft\olk\attachments\ooa-d851f35d-51ac-4c07-9554-2d32478c67f4\dc39a22da17d73676febb839f0b1a94e003332a03c936f48c9515ec4d8f64b55\medication information form and log (2025).docx

PLEASE TURN OVER FOR MEDICATION LOG

CITY OF NANAIMO THE HARBOUR CITY PARKS, RECREATION AND CULTURE	**MEDICATION LOG**

NAME OF PARTICIPANT: _____ BIRTHDATE: _____

DATES APPLICABLE: _____

For Option B medications; **Scheduled** Delivery:

- Leader is to complete this log **EVERY TIME** the child named above self-administers the medication according to the directions given on page 1 of the *Medication Information Form*.

MEDICATION LOG

MEDICATION NAME	DOSAGE	DATE/TIME GIVEN	LEADERS INITIALS

Form is to be returned to parent: at the end of the program, when medication is complete, or when form is full, whichever comes first. Additional logs can be attached if required.