



## **DAY CAMP PROGRAM STUDENT MEDICATION POLICY**

### **GUIDELINES**

The City of Torrance Community Services Department has established a Student Medication Policy for parents/guardians, participants and staff to follow when a participant needs to take medication during the Community Services Day Camp Program.

Please note: The policy guidelines listed below are for students that are able to administer their own medication. The City of Torrance Community Services Department has established a separate Severe Allergy Medication Policy for dealing with participants with severe allergies. A "severe allergy" is defined as an allergy that would pose a life threatening danger without immediate medical assistance. "Immediate" is defined as the need for assistance in less time than it would take for the paramedics to arrive. If you believe your child qualifies, please submit a note from your child's doctor stating the nature and treatment associated with their condition.

- The following are the guidelines of the Student Medication Policy. The policy is based on the state guidelines. All medications that will be taken during the program must be listed on the participant's form and must be accompanied by a Participant Health Form.
- The medication bottle provided by the parent/guardian must have the original prescription label complete with the participant's name, doctor's instructions and dosage.
- Over the counter medications will be allowed provided they are in their original bottle, and accompanied by a doctor's note prescribing their use. If it is necessary for the child to carry the medication at all times, the doctor needs to specify this on the form.
- A suitable measuring device should be sent along with the medicine if measuring is necessary.

### **STORAGE**

- All medications will be locked up in a location determined by the site supervisor.

### **ADMINISTERING MEDICATIONS**

- Staff will not administer any medication. Either the child, the parent/guardian or a care giver designated by the parent/guardian will be responsible for administering the medications at the appropriate times.
- Staff will make every effort to remind participants of scheduled medication times.

**PARTICIPANT MEDICATION POLICY: PARTICIPANT HEALTH FORM**

I. TO BE COMPLETED BY LICENSED PHYSICIAN

\_\_\_\_\_  
Participant's Last Name

\_\_\_\_\_  
Participant's First Name

\_\_\_\_\_  
Gender

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
School/Program

\_\_\_\_\_  
Diagnosis/Purpose of Medication(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_  
Dosage prescribed:

\_\_\_\_\_

\_\_\_\_\_  
Length of time medication will be necessary:

\_\_\_\_\_

\_\_\_\_\_  
Possible side effects:

\_\_\_\_\_

\_\_\_\_\_  
Action to be taken in case of side effects:

\_\_\_\_\_

\_\_\_\_\_  
Special instructions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I verify that this student is under my care and requires this medication.

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

II. TO BE COMPLETED BY PARENT/GUARDIAN

I request that my child, \_\_\_\_\_, be given access to his/her medication at the requested time. If this request is granted, I agree to hold the City of Torrance Community Services Department harmless in providing this service to my child. I hereby give consent to the Recreation staff.

I/we, \_\_\_\_\_, hereby agree to the above stated contract.

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Parent/Guardian Signature

Date

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Parent/Guardian Signature

Date