# Medication Guidelines

1. All medication's need to be labeled correctly in the original container or bottle dispensed.
2. All medications must be current, and cannot be expired.
3. Regarding glucose monitoring, specifically glucose fingerstick, equipment, and supplies: physician orders must be presented with equipment to be verified.
4. Regarding insulin: all insulin and supplies (syringes, pre-filled syringe needles) must be in original packaging, and must be stored in a locked cabinet or lock box.
5. Regarding respiratory medication's (inhalers, rescue inhaler's, etc.): must be labeled properly with pharmacy label, with prescribing physician name and information.
6. All narcotics (pain medication's, anxiety, medication's, sleeping medication, etc.: must be kept in a locked box or cabinet. (Must remain separate from other medications and kept secure.)
7. All emergency anaphylactic medication i.e.: epi-pens, must be properly labeled and not be expired. Must be kept in a secure location within close proximity to the teen. (For example with a team leader. I will organize this and ensure they are in a lock box)
8. Unless included in the first aid kit, all other, NSAIDs, vitamins, and other various over-the-counter medications must be administered by the nurse, labeled and not expired. **(This includes melatonin)**.
9. All allergy medications, including over-the-counter nasal sprays, NyQuil, and Visine, or artificial tears must be listed as a medication for the patient/Camper/volunteer. **These medications must be left with the nurse.**
10. Regarding hormones:
    a. injectable hormones: follow the same rules for insulin, and subsequent supplies.
    b. oral hormones (including birth control): must be kept with the camp nurse.
11. Parents/guardians must grant written permission for administering over-the-counter medications for the purposes of treating cramps related to menses.
12. Parents/guardians must grant written permission for administering over-the-counter NSAIDs, in case of emergency, related to injury, muscle cramps, or generalized pain.
13. All other supplies related to medications MUST be verified by the nurse. Including first aid supplies used routinely.
14. All physician information must be disclosed for all prescribed medications, including name, address, and phone number.

If you have any other questions or concerns, please don't hesitate to reach out and I will get those questions answered as soon as possible.

- Color Splash Out Team

**Color Splash Medical Form** **Youth's Name: _____**

I hereby request that the following medications be given to: _____
(Youth's Name)

Date of birth: _____ during the week of _____

Place all medications and this form into a Ziploc bag.

1. Only our assigned medical personnel are authorized to dispense medications.
2. In the case of inhalers for allergies or asthma, the student can carry inhalers during all activities.
3. All unused medications will be returned to parents when you pick up your teen.

| **Medicine Name** | | **RX Number:** | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Dosage:** | | **Time Required:** | | | | | | |
| | | **Mon.** | **Tues.** | **Wed.** | **Thurs.** | **Fri.** | **Sat.** | **Sun.** |
| **Breakfast** | | | | | | | | |
| **Lunch** | | | | | | | | |
| **Dinner** | | | | | | | | |
| **Bedtime** | | | | | | | | |

| **Medicine Name** | | **RX Number:** | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Dosage:** | | **Time Required:** | | | | | | |
| | | **Mon.** | **Tues.** | **Wed.** | **Thurs.** | **Fri.** | **Sat.** | **Sun.** |
| **Breakfast** | | | | | | | | |
| **Lunch** | | | | | | | | |
| **Dinner** | | | | | | | | |
| **Bedtime** | | | | | | | | |

**Color Splash Medical Form** **Youth's Name: _____**

| Medicine Name | | RX Number: | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Dosage: | | Time Required: | | | | | | |
| | | Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
| Breakfast | | | | | | | | |
| Lunch | | | | | | | | |
| Dinner | | | | | | | | |
| Bedtime | | | | | | | | |

| Medicine Name | | RX Number: | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Dosage: | | Time Required: | | | | | | |
| | | Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
| Breakfast | | | | | | | | |
| Lunch | | | | | | | | |
| Dinner | | | | | | | | |
| Bedtime | | | | | | | | |

List below all allergies: