CAMP SEQUOIA 2020 MEDICATION FORM

PLEASE FORWARD:
Copy 1: To Pharmacy along with prescriptions
Copy 2: To Camp Sequoia Office
Copy 3: Retain for your records

TIME LINES: FORM MUST BE RETURNED BY:
Full Season Campers: May 3
1st Session Campers: May 3
2nd Session Campers: May 24
Additional charges may occur after these dates

1. CAMPER'S NAME _____ DATE OF BIRTH _____

2. Session Attending (Please circle): Full Season 1st Session 2nd Session

3. (Check one) _____ **MY CHILD DOES TAKE MEDICATIONS, VITAMINS OR OVER-THE-COUNTER PRODUCTS.**
_____ **MY CHILD DOES NOT TAKE MEDICATIONS, INCLUDING VITAMINS OR OVER-THE-COUNTER PRODUCTS.**

5. MEDICATION(S) TO BE ADMINISTERED (Include vitamins and ALL over- the- counter medications to be administered)

MEDICATION	TOTAL DAILY DOSAGE (MG)	MEDICATION	TOTAL DAILY DOSAGE (MG)
A)		F)	
B)		G)	
C)		H)	
D)		I)	
E)		J)	

6. SCHEDULE OF ADMINISTRATION

TIME	NAME OF MED	DOSAGE (MG)	TIME	NAME OF MED	DOSAGE
(MG) BREAKFAST 8AM			MID-PM 3:30 - 4PM		
MID-AM 11AM			DINNER 6PM		
LUNCH 12:45 PM			BEDTIME 8:30 - 9PM		

Note: Camp Sequoia does a Sunday Brunch and early afternoon snack. Unless specified otherwise below, Sunday breakfast meds will be given at 10 am.

7. MEDICATION(S) OR OTC PREPARATIONS TO BE ADMINISTERED AT OTHER TIMES:

TIME	NAME OF MED	DOSAGE (MG)	TIME	NAME OF MED	DOSAGE(MG)

8. NAME OF PRESCRIBING PHYSICIAN _____ **TEL #** _____

ADDRESS _____ **FAX #** _____

I HEREBY AUTHORIZE CAMP SEQUOIA, LLC TO ADMINISTER THE ABOVE LISTED MEDICATIONS TO MY CHILD AS DIRECTED

PARENT SIGNATURE _____ **DATE** _____

PARENT'S NAME _____ **CONTACT #** _____

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CAMPER'S NAME_____ **DATE OF BIRTH**

Session Attending (Please circle): Full Season 1st Session 2nd Session

PARENT FILLING OUT FORM NAME **PARENT EMAIL**

ADDRESS
Street Address City State Zip

HOME PHONE **MOBILE PHONE** **FAX**

I _____ **GUARANTEE PAYMENT FOR THE ACCOUNT OF** _____
Parent Name Camper Name

A RESIDENT AT CAMP SEQUOIA BOTH DURING HIS STAY AND UPON DISCHARGE UNTIL THE ACCOUNT IS PAID IN FULL.

PLEASE SEND A COPY OF THE FRONT AND BACK OF YOUR CREDIT CARD ALONG WITH THIS FORM

CREDIT CARD INFO: Visa Master Card___ Discover___ Other (Name)__

CARD# **NAME ON CARD**

EXPIRATION DATE **SIGNATURE OF GUARANTOR**

INSURANCE INFORMATION

COMPANY **ID#** **GROUP**

NAME OF CONTACT PERSON, IF ANY **PHONE**

NOTE:

Neither Sellersville Pharmacy nor Camp Sequoia accepts AMEX.

PLEASE ATTACH A PHOTOCOPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD(S) TO THIS FORM

SPECIAL INSTRUCTIONS---THIS SECTION MUST BE COMPLETED AND SIGNED FOR PROCESSING

IF MY CARRIER REJECTS YOUR FIRST SUBMISSION (CHECK A OR B BELOW)

A) I UNDERSTAND THAT YOU WILL BILL MY CHILD'S PRESCRIPTION TO MY CREDIT CARD AT FULL COST AND I WILL PURSUE REIMBURSEMENT, **OR**

B) YOU ARE AUTHORIZED TO INVESTIGATE COVERAGE AND RESUBMIT FOR A FEE OF $25.00

PLEASE CHECK BELOW EVEN IF YOUR CAMPER DOES NOT TAKE PRESCRIPTION MEDICATIONS AT CAMP

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING THE COST OF PACKAGING MY CAMPERS VITAMINS, SUPPLEMENTS AND OVER---THE---COUNTER MEDICATIONS.

PARENT SIGNATURE **DATE**