

2026

CHILD'S NAME: _____

DATES ATTENDING: _____



AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION FROM HOME

**Please note: ONE FORM PER MEDICATION
For ALL Routine and Over-the-counter!**

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Camper Date of Birth ____/____/____

Today's Date ____/____/____

Medication Name _____ Controlled Drug? YES NO

Dosage _____ Method _____ Time(s) of Administration _____

Specific Instructions for Medication Administration _____

Medication Administration: Start Date ____/____/____ Stop Date ____/____/____

This authorization is extended for all camp programs within one (1) year of "Today's Date" above

Is this medication to be self-administered by the child? YES NO

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug: Allergies? YES NO Reactions to? YES NO Interactions with? YES NO

If "yes" to any of the above, please explain _____

Prescriber's Name _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____

Parent/Guardian Authorization:

I request that medication be administered to my child as described and directed above.

Name of Camp _____ Today's Date ____/____/____

Camper Name _____ Address _____ Town _____

Name of Parent/Guardian Authorizing Administration of Medication as described and directed above:

First Name _____ Last Name _____

Relationship to Child: Mother Father Guardian/Other explain: _____

Address _____ Town _____ Phone Number (____) _____

Parent/Guardian Signature _____

Camp Staff Receiving Written Authorization and Medication _____

Title/Position _____ Signature _____