2025

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 _____