2020

CHILD'S NAME: _____

DATES ATTENDING: _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION FROM HOME

Please note that a separate form is required for each Routine and Over-the -counter medication that accompanies the camper to camp!

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

Childôs Date of Birth _____/_____/_____ Todayôs 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 ñTodayôs Dateò 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 ñyesòto any of the above, please explain _____

Prescriberôs Name_____ Phone Number (_____) _____

Prescriberôs 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 _____ Todayôs Date _____/_____/_____

Childôs 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 (_____) _____

Signature of Parent/Guardian Authorizing Administration of Medication _____

Camp Staff Receiving Written Authorization and Medication _____

Title/Position _____ Signature _____