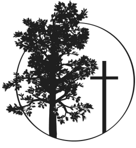
2023

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 ______/______/______ Todayqs 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 %Todayqs 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 ____

Prescriberqs Name_______________________________________ Phone Number (_____) _______________

Prescriberqs 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 ____ Todayqs 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 ____