



**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 \_\_\_\_\_