PARENT AND PRESCRIBER AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT CAMP

I request that my child _____age_____ receive the medication/s as prescribed by our licensed health care provider. The medication is to be furnished by me in a properly labeled original container from the pharmacy. I understand that the camp nurse, or other designated person, will administer the medication.

Signature (parent of Guardian):_____

Address:_____

Telephone #'s:

Home_____ Work_____ Cell_____ Date_____

To be completed by the licensed health care provider:
I request that my patient, as listed below, receive the following medication/s:

Name of camper:_____ Date of Birth:_____

1. Diagnosis:_____Name of medication:_____
Prescribed Dosage, frequency, route of administration and time/s:
_____
Possible side effects and adverse reactions (if any):
_____
2. Diagnosis:_____Name of medication:_____
Prescribed Dosage, frequency, route of administration and time/s:
_____
Possible side effects and adverse reactions (if any):
_____
3. Diagnosis:_____Name of medication:_____
Prescribed Dosage, frequency, route of administration and time/s:
_____
Possible side effects and adverse reactions (if any):
_____

Name/Title of Health Care provider **(please print**) _____

Signature:_____Date:_____

Address:_____Phone:_____

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