AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

A. TO BE COMPLETED BY PARENT OR GUARDIAN:

I REQUEST THAT MY CHILD _____, GROUP_____ RECEIVE THE MEDICATION AS PRESCRIBED BELOW BY OUR LICENSED HEALTH CARE PROVIDER. THE MEDICATION IS TO BE FURNISHED BY ME IN THE PROPERLY LABELED ORIGINAL CONTAINER FROM THE PHARMACY. (INHALERS MUST BE IN THE ORIGINAL BOX). I UNDERSTAND THAT THE CAMP NURSE, OR ANOTHER AUTHORIZED FIRST AID CERTIFIED STAFF MEMBER WILL ADMINISTER THE MEDICATION.

SIGNATURE (PARENT/GUARDIAN) _____

ADDRESS: _____

TELEPHONE: HOME _____ WORK _____

CELL _____ OTHER _____ DATE_____

B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER:

I REQUEST THAT MY PATIENT, AS LISTED BELOW, RECEIVE THE FOLLOWING MEDICATION:

NAME OF CAMPER: _____DATE OF BIRTH_____

DIAGNOSIS:_____

NAME OF MEDICATION: _____

PRESCRIBED DOSAGE, FREQUENCY AND ROUTE OF ADMINISTRATION:

_____

TIME TO BE TAKEN DURING CAMP HOURS: _____ DURATION OF TREATMENT_____

POSSIBLE SIDE EFFECTS AND ADVERSE REACTIONS (IF ANY):_____

_____

OTHER RECOMMENDATIONS: _____

NAME OF LICENSED PRESCRIBER AND TITLE (PLEASE PRINT): _____

PRESCRIBER'S SIGNATURE: _____DATE: _____

ADDRESS: _____ PHONE: _____