PARENT AND PRESCRIBER AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT CAMP

I request that my child ________________________ Age _______ receive the medications as prescribed by our licensed healthcare provider. The medication is to be furnished by me in a properly labeled original container from the pharmacy. I understand that the camper will be required to self-administer or parent, under the guidance of the healthcare director,

Signature (Parent or Guardian): ____

Address: ____

Telephone #s

Home:________________________ Work:______________________ Cell:_______________________

To be completed by a licensed healthcare provider:
I request that my patient, as listed below, receive the following medications/s:

Name of Camper:____ D.O.B:________________

Diagnosis:________________________________ Name of Medication:___________________________________

Prescribed Dosage: ____

Frequency: ____

Route of Administration: ____

Time/s: ____

Possible Side Effects: ____

Name/Title of Healthcare Provider (**please print**):____

Signature:____ Date:__________________________

Address:____ Phone #:____________________