CAMP SUNRISE/SNOWBALL VOLUNTEER COUNSELOR/PARENTAL & PHYSICIAN'S AUTHORIZATION FOR ADMINISTERING PRESCRIPTION MEDICATIONS

(*Must be completed for volunteers under age 18 who are taking prescription medications.*)

INSTRUCTIONS:

1. **ALL** prescription medications **MUST** be brought to Camp in the original container dispensed from the pharmacy with proper labeling.
2. The medication MUST be brought to Camp accompanied by **A COPY OF THIS FORM**. Be sure you have included all of the following information: a) counselor's name, b) name of drug, c) dosage and frequency, d) doctor's name, address and telephone number, e) possible side effects, f) condition being treated and g) doctor's signature.

AUTHORIZATION FOR DISPENSING PRESCRIPTION MEDICATION

To be completed by Parent/Guardian

I request that _____, age _____ receive the medication as prescribed below by his/her physician. This medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the Camp Nurse or other designated person will administer the medication. I understand that unless otherwise indicated, the Camp Nurse will administer over-the-counter medications as needed.

_____	_____	_____
Parent/Guardian Signature	Telephone Number	Date

TO BE COMPLETED BY PHYSICIAN

I request that my patient, as listed below, receive the following medication:

Patient Name: _____ Age: _____

Diagnosis: _____

NAME OF MEDICATION	PRESCRIBED DOSAGE & MEANS OF ADMINISTERING	TIME TO BE ADMINISTERED	EXPECTED DURATION OF TREATMENT	POSSIBLE SIDE EFFECTS & ADVERSE REACTIONS

Physician Name (please print): _____

Physician Signature: _____

Telephone No.:_____ Date: _____

Office Hours: _____

PLEASE REPRODUCE IF YOU NEED TO LIST ADDITIONAL INFORMATION