# CAMP SUNRISE COUNSELOR/PARENTAL & PHYSICIAN'S AUTHORIZATION FOR ADMINISTERING PRESCRIPTION MEDICINES

## 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 for all counselors under the age of 18.***

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. My physician has also completed the over-the-counter medications authorization for this camper. 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 |
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Physician Name (please print): _____

***Physician Signature***: _____

Telephone No.:_____ Date: _____

Office Hours: _____

PLEASE REPRODUCE IF YOU NEED TO LIST ADDITIONAL INFORMATION