AUTHORIZATION FOR ADMINISTERING PRESCRIPTION MEDICATIONS

INSTRUCTIONS

1. Read the following carefully.
2. Complete the AUTHORIZATION FOR ADMINISTERING PRESCRIPTION MEDICATIONS form below and obtain your physician's signature.
3. Either send this form to the Camp Registrar or bring it with you when you register at check-in.
4. A camper who requires medication **MUST** either send the form (below) to the Camp Registrar or present the form at registration.

WHEN BRINGING MEDICATIONS TO CAMP:

1. **ALL** medications **MUST** be brought to camp in the original container dispensed from the pharmacy with the proper labeling.
2. The medication should be brought to camp accompanied by **A COPY OF THIS FORM** . Be sure you have included all of the following information: a) camper'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.

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. My physician has also completed the over-the-counter medication 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, listed below, receive the medication(s) as listed below.

_____ _____

Patient Name | Age

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

PHYSICIAN NAME (printed) _____ DATE _____

Physician Signature: _____ Telephone Number: _____

Office Hours: _____

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