AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER

(To be completed by parent/guardian)

Name of Camper: _____ Age: _____

Food/Drug Allergies: _____

Diagnosis (at parents discretion): _____

Parent/Guardian Name: _____

Home Telephone: _____

Business Telephone: _____

Emergency Telephone: _____

Name of Licensed Prescriber: _____

Business Telephone: _____

Emergency Telephone: _____

Name of Medication: _____ Dose given at camp: _____ Route of Administration: _____

Frequency: _____ Date Ordered: _____ Duration of Order: _____ Quantity Received: _____

Expiration date of Medications Received: _____ Special Storage Requirements: _____

Specific Directions (e.g., on empty stomach/with water): _____

Specific Precautions: _____

Possible Side Effects/Adverse Reactions: _____

Other medications (at parents' discretion): _____

Location where medication administration will occur: _____

(Over)