



Authorization for Self Administration of Medication by Camper

William and Mary Rowing Camp does not dispense any medications to campers. Campers who need to take prescription or over the counter medication must come to camp with authorization of self-administration of medication from both the parents and a physician. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and the date of the prescription. All medications must be given to the camp director, and campers must coordinate with the camp director times to access their medications. All unused medication will be destroyed if not picked up within one week following the camper's departure at the end of camp.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child _____ Date of Birth ___/___/___ Today's Date ___/___/___
Medication Name _____ Controlled Drug? ___ Yes ___ No
Dosage _____ Method _____ Time of Administration _____
Medication Administration: Start Date ___/___/___ Stop Date ___/___/___
Relevant Side Effects of Medication _____
Plan of Management for Side Effects _____
Known Food or Drug: Allergies ___ Yes ___ No Reactions to ___ Yes ___ No
If "yes" to any of the above, please explain _____
Prescriber's Name _____ Phone Number () _____
Prescriber's Address _____ Town _____
Prescriber's Signature _____

Authorization for self administration of medication:

I authorize _____ to self administer medication. The camper has been taught proper administration of this medication.

Prescriber's Signature _____

Parent/Guardian Authorization for Self Administration of Medication:

I request that my child can self medicate as described and directed above.

Name of Camp _____ Today's Date ___/___/___
Child's Name _____ Address _____ Town _____
Name of Parent/Guardian Authorizing self administration of medication _____
Relationship to Child : Mother ___ Father ___ Guardian/Other explain: _____
Address _____ Town _____ Phone _____
Signature of Parent/Guardian Authorizing Self Administration of Medication: _____

Name of Camp Personnel Receiving Written Authorization and Medication: _____

Title/Position _____ Signature (in ink) _____