AUTHORIZATION FOR PRESCRIPTION MEDICATION TO BE TAKEN AT CAMP

Summer 2015

The following section is to be completed by the PARENT:

Camper: _____ Home Phone: _____

Gender: _____ Age: _____ Date of Birth: _____

Parent's Name: _____ Parent's Name: _____

Business Phone: _____ Business Phone: _____

Cell Phone: _____ Cell Phone: _____

Physician's Name: _____ Phone: _____

Address: _____

I REQUEST THAT MY CHILD BE ASSISTED IN TAKING THE MEDICINE(S) DESCRIBED BELOW AT CAMP BY AUTHORIZED PERSONS. ***(If more than one medication is required, please complete a separate authorization form for each.)***

Name of medicine:
Reason for medication:
Form: ❑ Tablet ❑ Liquid ❑ Chewable ❑ Drops ❑ Other (specify)
Dose:
If medicine is to be given DAILY, at what time?
If medicine is to be given "WHEN NEEDED," describe indications:
Other comments:

Parent Signature: _____ **Date:** _____