AUTHORIZATION FOR PRESCRIPTION MEDICATION TO BE TAKEN AT CAMP

Summer 2018

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:** ______________