



AUTHORIZATION FOR PRESCRIPTION MEDICATION TO BE TAKEN AT CAMP

Summer 2019

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: <input type="checkbox"/> Tablet <input type="checkbox"/> Liquid <input type="checkbox"/> Chewable <input type="checkbox"/> Drops <input type="checkbox"/> 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: _____