AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER

To be completed by parent/guardian and countersigned by the health-care consultant

Camper: ______________________________
First name *Last name*

Parent/guardian name: ______________________

Date of birth: ____________
Month/day/year

Home telephone: ______________________

Business telephone: ______________________

Food/drug allergies: ______________________

Emergency telephone: ______________________

Diagnosis (at parent's discretion): ______________________________

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): ______________________________

Possible side effects/adverse reactions: ______________________________

Other medication (at parent's discretion): ______________________________

Location where medication administration will occur: ______________________________

NOTE: *Use reverse side if needed for any additional information*

All medication must be sent in the original container.
If any medication is left at the end of the week, it will be destroyed in the presence of a witness.
Privacy issues will be enforced as required by the HIPPA regulations.

____
Signature (parent/guardian)

____
Signature (health-care consultant)

____
Date

____
Date

Parental consent for camper ______________________ to keep inhaler/epipen on their person.

____
Signature (parent/guardian)

____
Date