



Physician's Authorization for Prescription Medications

If your doctor feels it is necessary for medication to be administered at camp, the following Part A needs to be completed by the Physician and Part B by a Parent/Guardian.

Please deliver your child's medication directly to the camp first aid staff in the original, properly labeled container. For Prescription Medication, labels should display:

1. Camper's Name
2. Name and Phone # of the pharmacy
3. Doctor's Name
4. Name, dose, frequency & route of administration of the medicine
5. Any other necessary directions

PART A: Completed by Physician

(Camper's Name) _____ has been under my care for _____ (Condition or Diagnosis).

Please administer the medication as follows (physician to fill out the following, include EpiPen/Asthma Inhalers for campers to carry):

Medication Name: _____

Dose: _____ Frequency: _____ Route: _____ Duration: _____

Medication Name: _____

Dose: _____ Frequency: _____ Route: _____ Duration: _____

Special Instructions: _____

Additional health information/major allergies _____

Medically prescribed meal plan or dietary restrictions _____

This applicant may participate in all camp activities: Yes _____ No _____ If no, please explain:

Physician Name & Signature: _____ Phone Number: _____ Date: _____

PART B: Completed by Parent/Guardian (For Prescription Medications & Chronic Conditions)

I have read and understand the top of this form. I hereby grant permission for my child to receive medication as directed by his/her physician.

Parent/Guardian Name & Signature _____ Date _____