

**AUTHORIZATION FORM**

**PARENT PRESCRIBER'S AUTHORIZATION FOR  
ADMINISTRATION OF MEDICATION AT CAMP**

*Authorization of administration of medication*

A. To be completed by the parent of guardian:

I request that my child \_\_\_\_\_ receive medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the Health Director will supervise my child taking her own medication:

Signature (Parent or Guardian): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Date \_\_\_\_\_

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Name of Camper: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Prescribed dosage, frequency and route of administration:  
\_\_\_\_\_

Time to be Taken: \_\_\_\_\_

Duration of Treatment: \_\_\_\_\_

Possible side effects and adverse reactions (if any): \_\_\_\_\_

Other Recommendations: \_\_\_\_\_

Name of licensed prescriber and title (please print): \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_