Medication Authorization

Camper's Name: _____

Licensed prescribing Practitioner's Name: _____

Practitioner's Telephone Number: _____

Name of Medication: _____

Dosage: _____

Time of Day medication is to be given: _____

Route of Medication: _____

Length of time the medication is to be given: _____

Reason for medication (unless this information needs to remain confidential):

_____

_____

_____

Side effects or reactions to watch for:

_____

_____

_____

Any other Special Instructions:

_____

_____

_____

_____

_____

_____

Practitioner Signature Date Authorized

Parent Authorization

The parent/guardian of _____ ask that staff give the following medication _____ at this time _____ to my child, according to the Health Care Provider's signed instructions on the attached Medication Authorization Form.

The Program agrees to administer medication prescribed by a licensed health care provider.
It is the parent/guardian's responsibility to furnish the medication.
The parent agrees to pick up expired or unused medication within one week of notification by staff.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's healthcare provider to share information about the administration of this medication with the staff delegated to administer medication.

Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

_____ _____

Work Phone Home Phone