Authorization for Prescription Medication & Over the Counter Medications to be Taken During Camp Day

This form MUST be signed by your child's physician.

I REQUEST THAT MY CHILD BE ASSISTED IN TAKING THE MEDICINE(S). DESCRIBED BELOW AT CAMP BY AUTHORIZED STAFF.

Camper: ________________________________ Home Phone: __________________

Grade (Entering 09/15):_____ Date of Birth: ___/___/_____ Gender: ☐ Male ☐ Female

Physician's Name: ___________________________ Physician's Phone: ______________

Parent 1: ___________________ Cell: ______________ Work: ___________________

Parent 2: ___________________ Cell: ______________ Work:____________________

I hereby give permission to the medical personnel selected by Camp Bay View, to administer medication to my child.

Parent Name: ___________________ Parent Signature:__________________ Date: _______

Name of Medication(s): ____

Reason Child is Taking Medication: ____________________________________

Form (Please Circle): Tablet Liquid Chewable Drops Other (specify):____________

Amount/Dose:___________________**Number of times Daily:** ________ **What time Daily:** ____________

If Medication Is To Be Given "AS NEEDED," Describe Indications:_________________________________

____

Comments:____

Authorized Prescriber

Prescriber's Name (Please Print): _________________________ Phone: _________________

Licensed Authorized Prescriber's Signature:__________________________ Date: _________

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