Authorization for Prescription Medication & Over the Counter Medication 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: _____

Name of Medication: _____

Reason Child is taking Medication: _____

Form: ☐ Tablet ☐ Liquid ☐ Chewable ☐ Drops ☐ Other (Specify)_____

Amount/Dose to be given: ____ **Number of times daily**: _____ **What time daily**: _____

If medication is to be given "AS NEEDED", describe indications:_____

_____

Comments: _____

I Hereby give permission to the medical personnel selected by Camp Arrowhead, to administer medication to my child.

Parent Name: _____ Parent Signature: _____ Date:_____

Authorized Prescriber

Prescriber's Name (Please Print): _____ Phone: _____

Licensed Authorized Prescriber's Signature: _____ Date: _____

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