AUTHORIZATION FOR DISPENSING MEDICATION
(EXCLUDING OVER THE COUNTER MEDICATION) AT CAMP
****OVER THE COUNTER MEDICATION FORM IS SEPARATE****

PARENT/GUARDIAN:

I request that my child _____
Camper's Name

receive the medication prescribed in the form below by _____
Physician's Name

_____ _____
Signature of Parent/Guardian Date

_____
Telephone No.

PHYSICIAN

I request that my patient receive the following medication:

Name of Camper: _____

Diagnosis: _____

Name of Medication _____

Prescribed Dosage: _____

Time to be taken during camp hours: _____

Expected duration of treatment: _____

Possible side effects and adverse reaction: _____

Other recommendations:_____

Print Name: _____ Telephone No. _____

Signature: _____ Date: _____