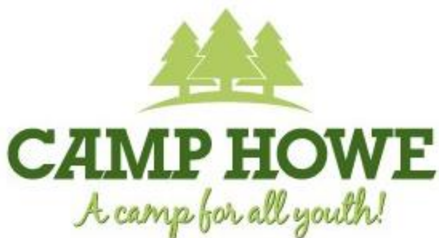

AUTHORIZATION TO ADMINISTER PRESCRIPION MEDICATION
and OVER THE COUNTER MEDICATION (NOT ON OUR MEDICATION LIST TO A CAMPER)

(To be completed by Doctor – One form per each medication)

Name of Child: ____ Date of Birth______________

Street Address:____

City/Town Address:____ State:________ Zip:______________

Allergies: ____

Information on Medication

Name of Medication:____

Condition for which medication is being given for: ____

Route of Administration:____

Dose given at camp: ____

Frequency: ____

Date Ordered:____Duration of Order: ________________________

Is this a controlled Medication: ____

Special Storage Requirements: ____

Specific Directions (e.g., on empty stomach/with water):____

Specific Precautions____

Possible Side Effects/ Adverse Reactions and Management:____

____

Physician or Dentist's Name____

Street Address:____City/Town_______________State______

Phone No. _________________________________

Physician or Dentist's Signature: ____________________________________Date: ________________________

Doctor

Camp Howe – A Camp for All youth!
P.O. Box 326
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www.camphowe.com