

PARENT AND PRESCRIBER'S AUTHORIZATION FOR
ADMINISTRATION OF MEDICATION AT **CAMP PELICAN**

Authorization for administration of medication

A. To be completed by the Parent or Guardian:

I request that my child _____ attending **Camp Pelican** receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the camp nurse or other designated person, in the case of the absence of the camp nurse, will administer the medication.

Signature (Parent or Guardian): _____

Address: _____

Telephone: _____

Date: _____

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Name of Camper: _____

Date of Birth: _____

Diagnosis: _____

Name of medication: _____

Prescribed Dosage and Means of Administering: _____

Time to be taken during camp hours: _____

Expected Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

Other Recommendations (including PRN or self-administration orders): _____

Name and Title of Licensed Prescriber (please print): _____

Signature: _____ Date: _____

Address: _____ Phone: _____