



MAPLEWOOD SCHOOL
& Summer Program

FOR CAMP ONLY. CAN NOT BE USED FOR OUR SCHOOL PROGRAM.

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
ONE FORM PER MEDICATION

A. TO BE COMPLETED BY PARENT OR GUARDIAN:

I REQUEST THAT MY CHILD _____, GROUP _____,
RECEIVE THE MEDICATION PRESCRIBED BELOW BY OUR LICENSED HEALTH CARE PROVIDER. 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 ASSIGNED PERSON WILL ADMINISTER
THE MEDICATION.

SIGNATURE (PARENT / GUARDIAN) _____

ADDRESS: _____

TELEPHONE: HOME _____ WORK: _____

CELL: _____ DATE: _____

B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER:

I REQUEST THAT MY PATIENT, AS LISTED BELOW, RECEIVE THE FOLLOWING MEDICATION:

NAME OF CAMPER: _____ DATE OF BIRTH: _____

DIAGNOSIS: _____

NAME OF MEDICATION : _____

PRESCRIBED DOSAGE, FREQUENCY AND ROUTE OF ADMINISTRATION: _____

TIME TO BE TAKEN DURING CAMP HOURS: _____

DURATION OF TREATMENT: _____

POSSIBLE SIDE EFFECTS AND ADVERSE REACTIONS (IF ANY): _____

OTHER RECOMMENDATIONS: _____

NAME OF LICENSED PRESCRIBER & TITLE: _____
(PLEASE PRINT)

PRESCRIBER'S SIGNATURE: _____ DATE: _____

ADDRESS: _____ PHONE: _____