Authorization for Administration of Prescription Medication

YEAR: _____
For Office Use only

Important Information: This Form is required for every Camper attending camp who may need prescription medication. Please return this form to Camp DeWolfe no later than June 15. After June 15, a $100 Late Fee will be applied to any account with an outstanding balance or missing forms.

Complete one form for EACH medication required.

CAMPER INFORMATION (TO BE COMPLETED BY PARENT / GUARDIAN)

First Name: **Last Name:** **Date of Birth:**

Camp DeWolfe Session Information **Session Start Date:** **Session End Date:**

Street Address: **City:**

State: **Zip:** **Primary Phone**

PARENT / GUARDIAN AUTHORIZATION

I AUTHORIZE CAMP DEWOLFE TO ADMINISTER MEDICATION TO MY CHILD AS DESCRIBED AND DIRECTED BY THE AUTHORIZED PRESCRIBER:

Parent/Guardian Printed Full Name **Signature** **Date**

Relationship to Camper:

Street Address: **City:**

State: **Zip:** **Primary Phone**

AUTHORIZED PRESCRIBER'S ORDER

Prescriber, the Parent / Guardian of the Camper listed above has indicated the need for prescription medication while at camp.

This Camper Takes the Following Prescription Medication: **Today's Date:**

☐ ***Check if this Authorization is valid for all Camp Programs within One (1) Year of 'Today's Date."***

Medication Name	Dosage / Method / Frequency	Special Instructions for Administration
Check if Controlled Drug		☐ *Check if Medication may be self-administered by Camper.*

Relevant Side Effects or Reactions to medication? ☐ **Yes** ☐ **No**

Known Allergic reactions: *Food or Drug* ☐ **Yes** ☐ **No** *Other Reaction:* ☐ **Yes** ☐ **No**

Please Explain if 'Yes' to any:

Prescriber Signature ***Prescriber Printed Name*** ***Date Signed***

Address: ***Phone:***