## **Medication Authorization**

Camper's Name:	
Licensed prescribing Practitioner's Name:	
Practitioner's Telephone Number:	
Name of Medication:	
Dosage:	
Time of Day medication is to be given:	
Route of Medication:	
Length of time the medication is to be given:	
Reason for medication (unless this information needs to remain confident	ial):
Side effects or reactions to watch for:	
Any other Special Instructions:	
Practitioner Signature	Date Authorized

## **Parent Authorization**

The parent/guardian of		ask that staff give the following	
medication	at this time	to n	ny
child, according to the Health Care Provi	der's signed instructions o	n the attached Medication	
Authorization Form.			
The Program agrees to administer med	ication prescribed by a lice	nsed health care provider.	
It is the parent/guardian's responsibilit	y to furnish the medicatio	1.	
The parent agrees to pick up expired or	unused medication withi	one week of notification by staff	f.
<b>Prescription medications</b> must come in	a container labeled with: o	hild's name, name of	
medicine, time medicine is to be given, o	dosage, and date medicine	is to be stopped, and licensed	
health care provider's name. Pharmacy	name and phone number r	nust also be included on the label.	
Over the counter medication must be la	beled with child's name. [	osage must match the	
signed health care provider authorization	n, and medicine must be p	ackaged in original container.	
By signing this document, I give permiss	sion for my child's healtho	are provider to share information	
about the administration of this medica	ation with the staff delega	ted to administer medication.	
Parent/Legal Guardian's Name	Parent/Legal Guardian Sig	nature Date	<del></del>
Work Phone	Home Phone		