PERMISSION FOR MEDICATION ADMINISTRATION

Only if your child will be taking medication on site

Name of Child _____ Age _____

Primary Healthcare Provider _____

Medication_____Dosage_____

Route_____Purpose of Medication_____

Time of day medication is to be given _____

Possible side effects_____

Anticipated number of days it needs to be given at the facility. _____

I hereby give my permission for_____to take the above prescription or over-the-counter medication at Camp Apex as ordered. I understand that it is my responsibility to furnish and refill this medication.

Parent/Guardian Signature_____ Date _____

Signature of Physician Prescriptive Authority (i.e., Doctor)_____Date _____

Note: The prescription medication is to be brought to the facility in its original pharmacy container, appropriately labeled by the pharmacy or person with prescriptive authority, along with a copy of the medication authorization order. We are unable to give any medication – prescription or over the counter – without a written authorization from a prescriptive authority.