

Reviewed by Camp RN

Initial: _____ Date: _____

Camp Bennett

Medication Administration Authorization Form

This order must be completed and signed by a physician and is valid only for the summer of _____

Name of Participant: _____ DOB: _____

Camp/program: _____ Week(s)/Session(s) _____

Medication Time Codes:

B - Breakfast 8:00am - 9:00am **L** - Lunch 12:00pm - 1:00pm

D - Dinner 5:00pm - 6:30pm **N** - Bedtime 9:00pm - 9:30pm

**Note to Physician:* Please write legibly as this form will also serve as the Medication Administration Record.

Med/Dose/Route/Interval	Dose	Time	Sun	Mon	Tues	Wed	Thur	Fri
		B						
		L						
		D						
		N						

Doctor's Signature: _____ **Date:** _____

Parent/Guardian Authorization:

I request designated camp personnel to administer the medication as prescribed above. I understand that at the end of the camp session, an adult must pick up the medication, otherwise it will be discarded. I authorize the camp nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Doctor's Stamp

(If no stamp, please write in address/phone)