CAMP SUMMERSET
Medication/ Prescription Drug Authorization Form

CHILD'S NAME _____ Age _____ Date _____

Reason for Medication: _____

Name of Medication: _____ RX # _____

Strength _____ Dosage _____ Dispense at (time) _____

Optional Comments or Side Effects we should be aware of:

_____

_____

_____

_____

Physician's Name: _____ Phone: _____

_____

Signature of Physician *Date*

I authorize the Camp Summerset Health Designees to give this medication to my child and confirm that at least one dose of this medication has been given to my child at home.

_____If checked, my child is allowed to self-administer this medication in the presence of an adult.

_____

Parent/Guardian's Name (print)

_____

Signature of Parent/ Guardian *Date*

The medication must be in its original container bearing a pharmacy label which shows the patients name, the medication prescription number, date filled, prescribing physician's name, name of medication, directions for taking the medication. **Any changes to medications administered during camp sessions must be communicated to a Camp Director in writing using this form.**