



MERRIMACK PARKS & RECREATION
CAMP NATICOOK & CAMP TREK
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Phone: 603-882-1046 Fax: 603-883-5335
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AUTHORIZATION TO ADMINISTER MEDICATION

This form must be completed fully in order for Camp Naticook or Camp Trek to administer the required medication. All medications will be securely stored in the Camp Health Center & distributed as directed by these orders. One form must be completed for each medication.

- Prescription medication shall be labeled in its original container, with the child's name, the name of the drug, and the directions for its administration and storage.
- Non-Prescription medication includes over the counter medications including acetaminophen, Motrin, Tylenol, vitamins, homeopathic, and herbal medications and must be in the original container with the label intact.

PREScriber's AUTHORIZATION

1. Child's First & Last Name:	2. Child's Date of Birth: ____ / ____ / ____
3. Child's Height:	4. Child's Weight:
5. Medication Name:	6. Is this an Emergency Medication? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Condition for which medication is being administered:	
8. Dosage:	9. Time/Frequency:
10. Directions for administration (routine or PRN)	
11. Relevant Side Effects: <input type="checkbox"/> None Expected <input type="checkbox"/> Specify:	
12. If emergency medication (Inhaler or Epi Pen) can child self-administer it? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type or Print Prescriber's Name: _____	
Telephone: _____	Fax: _____
Prescriber's Signature: _____ Date: _____	

I/We request designated Camp Personnel to administer the medication as prescribed by the above prescriber.
I/We certify that I/We have legal authority to consent to medical treatment for the camper named above, including the administration of medication. I understand that I/We must pick up the medication at the end of my child's sessions or the medication will be destroyed. I authorize Camp personnel to communicate with the prescribing health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____