Permission for Medication Administration

A copy of this form must be completed by the prescribing practitioner for EACH medication (including over-the-counter or prescription, vitamins, and topical treatments). Any medication brought to camp without this form cannot be administered.

The parent/guardian of _____ ask that CCYC camp staff give the
Child's Name

following medication _____ at _____
Name of Medicine & Dosage Time(s)

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, route, date medicine is to be stopped, and licensed Health Care Provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child's name. Dosage must match the signed Health Care Provider authorization, and medicine must be packaged in original container.

The camp agrees to administer medication prescribed by a licensed Health Care Provider with prescriptive authority. The parent agrees to pick up expired or unused medication at camp check-out or within one week of notification by staff in the event medications were not collected at check-out. All medication(s) left at the camp will be discarded according to the most current state regulatory recommendations for safe medication disposal.

By signing this document, I give permission for my child's Health Care Provider to share information about the administration of this medication with the camp staff delegated to administer medication.

_____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

_____ _____
Work Phone Alternate Phone

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Health Care Provider Authorization

Child's Name:		Birthdate:
Medication:	Dosage:	Route:
To be given at the following times:	Start Date:	End Date:
Special Instructions:		
Purpose of Medication:		
Side Effects to be reported:		

_____ _____
Signature of Health Care Provider with Prescriptive Authority Date

_____ _____
Print Name of Health Care Provider Phone Number