Medication Authorization

Child's Name_____ Date of Birth_____

Name of Medication_____ Dosage _____ Time_____

Reason for Medication_____

Child's Physician_____

Parent/Guardian's Name (Please print)_____

Parent/Guardian's
Signature_____Date_____

- Medication must arrive to camp in the original prescription bottle.

To be completed by Staff person upon administration of Medicine

Date	Time	Dosage	Signature of Staff

Date	Time	Dosage	Signature of Staff

Date	Time	Dosage	Signature of Staff

Date	Time	Dosage	Signature of Staff

Date	Time	Dosage	Signature of Staff

Date	Time	Dosage	Signature of Staff

Date	Time	Dosage	Signature of Staff

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