COMPLETE ONLY IF MEDICATION IS NEEDED DURING CAMP HOURS
Summer at Stanley
Medication Administration

The parent/legal guardian of _____ asks that Summer at Stanley staff give the

following medication _____ **at** _____ _____
(Name of medicine and dosage) (Times)

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

Summer at Stanley agrees to administer only medication prescribed by a licensed health care provider or dentist and provided by the parent or legal guardian.

Prescription medications must come in a container labeled with the child's name, the name of the medication, when the medication is to be administered, the dosage, the date when the medication is to be stopped, and the licensed health care provider's name. The pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with the child's name, the dosage must match the signed health care provider authorization, and the medicine must be packaged in the original container.

By signing this document, I give permission for my child's health care provider/clinic to share information regarding my child's illness/injury with Summer at Stanley.

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

_____ _____ / _____
Name of Health Care Provider Prescribing Medication Phone Fax

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Health Care Provider Authorization

Child's Name: _____ Birthdate: _____

Medication: _____

Dosage: _____ Route: _____

Special Instructions: _____

To be administered at the following time(s): _____ _____

Purpose of medication: _____

Possible side effects: _____

Starting Date: _____ Ending Date: _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority Prescriptive Authority #

PLEASE ASK YOUR PHARMACIST FOR A SEPARATE MEDICATION BOTTLE TO KEEP AT CAMP TO ENSURE CONSISTENCY IN MEDICATION ADMINISTRATION. THANK YOU!