I, _____ authorize the administration of _____
First Name & Last Name Name of Medication

to _____ for _____
Child's Name Reason

by the Camp Director or a staff member designated by the Camp Director.

Date medicine started: _______________
Month Day Year

Date medicine started at Creative Encounters: _______________
Month Day Year

End Date: _____ Dosage: _____

Times of administration:

1. _____ 2. _____

3. _____ 4. _____

Is refrigeration required? Yes _____ No _____

Special Instructions: (e.g. "Must be taken with food")

_____
_____

Side effects:

_____
_____

Stop medication if the following reaction(s) observed: _____

_____

Has this medication been prescribed by a physician? Yes _____ No _____

If **yes**: prescribing physician's name: _____ Phone #: _____

_____ _____
Parent/Guardian's Signature Date

PLEASE FILL OUT FORM COMPLETELY

Prior to administering, medication must be authorized by Director, Supervisor or designate.