Request for Administration Of Medication Form

All medications MUST be in the original container in order for them to be administered.

Box 1 must <u>ALWAYS</u> be completed by the parent/guardian

Box 1: Parent/Guardian Instructions – use one form per medication/product
(Check all that apply)

☐ Nonprescription Medication ☐ Food Supplement

☐ Topical Product
(sunscreen, insect repellent, etc.)

Complete all of the following information:

Name of Child: ____________________ **Birth Date:** ____________________ **Weight:** ________

Name of Medication/Product: ______________________________ **Exact Dosage:** __________

To Be Administered at the following times: ____

For the following period of time: 6/3/2019 through 8/9/2019

X Signature of Parent/Guardian __________________________________ **Date:** __________

Box 2 must <u>ALWAYS</u> be completed by a licensed physician, licensed dentist, or advance practice nurse.

Box 2: Physician Instructions – use one form per medication/product
(Check all that apply)

☐ Prescription Medication ☐ Medication contains codeine/aspirin

☐ Sample Medication
(without a prescription label)

Complete all of the following information:

(Name of Child) ___________________________________ is under my care and should receive
(Name of Medication) ____ (Dosage) __________
as follows ____
Specific instructions for administration: ____
____
Possible side effects to watch for: ____
Expiration date (may not exceed 12 months from date of this request): ___________________

X Signature of Physician _____________________ **Date:** __________ **Phone #:** __________

Box 3 is for camp staff use only, and is to be completed by a designated person:

(Name of Child) _______________________________________ was given (name of medication, vitamin, or modified diet) ____ (Dosage) __________ at the following time(s) on the following date(s): *(see below)*

Date of Dosage	Amount and Time of Dosage	Signature of Designated Person Administering Medication

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