

# Request for Administration Of Medication Form

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

Box 1 must **ALWAYS** 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: \_\_\_\_\_

**X** Signature of Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

Box 2 must **ALWAYS** 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)*

<b>Date of Dosage</b>	<b>Amount and Time of Dosage</b>	<b>Signature of Designated Person Administering Medication</b>

