CAMP ACWORTH

AUTHORIZATION FOR MEDICATION

Child's Full Name: _____ Child's Date Of Birth: _____

Name Of Medication: _____ Prescription #: _____

Time of Day Medication Is To Be Given: _____ Taken With Food Y/N? _____

Camp Weeks To Be Given: _____

Camp Location (separate form needed per camp): - Select Camp Location -

Medication Instructions for Staff: _____

_____

_____

Prescription medication will not be given on an "As Needed" basis, specific instructions must be provided. By filling out and signing this form, you give Camp Acworth Staff, including the Camp Director, Assistant Camp Directors and/or Camp Counselors, permission to administer the above mentioned medication to your child based on the protocol you, the parent, have listed above.

_____ _____ _____

Parent Name ***Parent Signature*** ***Date***

For Camp Staff Use (Reminder: Please document any reasons why medications ARE NOT given as parent has requested ie. Child absent, no medication remaining, parent request etc…)

	DATE	TIME GIVEN	AMOUNT GIVEN	ADVERSE REACTIONS?	STAFF INITIALS
1.					
2.					
3.					
4.					
5.					

If noticeable adverse reaction to medication, what action was taken? Describe below:

_____

_____

_____

Parents/ Guardians Please Note:
This form must be completed in its entirety before Camp Acworth staff can dispense any medication