

**IN ORDER FOR THE CAMP TO ADMINISTER ANY MEDICATION, THIS FORM MUST BE COMPLETED BY BOTH A PHYSICIAN AND A PARENT, AND PRESENTED ON THE FIRST DAY OF CAMP.**

**MEDICATION ORDER 2009**

(To be completed by a Licensed Prescriber: Physician, Nurse Practitioner or others authorized by Chapter 94C)

Name of Camper \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city/town)

Name of Licensed Prescriber \_\_\_\_\_ Title \_\_\_\_\_

Business Telephone Number \_\_\_\_\_

Emergency Telephone Number \_\_\_\_\_

Name of Medication \_\_\_\_\_

Route of Administration \_\_\_\_\_ Dosage \_\_\_\_\_

Frequency \_\_\_\_\_ Time(s) of Administration \_\_\_\_\_

Specific Directions or Information for Administration \_\_\_\_\_

Date of Order \_\_\_\_\_ Discontinuation Date \_\_\_\_\_

Diagnosis \_\_\_\_\_

Consent for Self-Administration (Provided the nurse determines it is safe and appropriate).

Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Signature of Licensed Prescriber

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**PARENTAL CONSENT**

1. I give permission to have the camp nurse or staff designated by the nurse to give the following medicine \_\_\_\_\_ prescribed by \_\_\_\_\_  
(name of medicine) (licensed prescriber)  
to \_\_\_\_\_.  
(name of camper)
2. I give permission for my son/daughter to self-administer medication if the camp nurse determines it is safe and appropriate. Yes \_\_\_\_\_ No \_\_\_\_\_
3. I give permission to the camp nurse to share with the appropriate camp personnel information relative to the prescribed medicine administration, e.g., adverse side effects, as he/she determines necessary for my son's/daughter's health and safety.  
Yes \_\_\_\_\_ No \_\_\_\_\_ Any restrictions on release \_\_\_\_\_

(Please note: I understand that I may retrieve the medicine from the camp at any time and that the medicine will be destroyed if it is not picked up by September 15, 2009.)

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_