

Extreme Destination Camp 2011

South Seaville Camp Meeting

188 Dennisville Road

SOUTH SEAVILLE NJ, 08246

AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER

(To be completed by parent/guardian and reviewed with the camp nurse)

Name of Camper: _____

Parent/Guardian Name: _____

Age of Camper: _____ Sex of Camper: _____

Home Telephone: _____

Food/Drug Allergies: _____

Business Telephone: _____

Diagnosis (relevant to administration of medication) _____

Emergency Telephone: _____

Name of Licensed Prescriber: _____

Business Telephone: _____

Emergency Telephone: _____

Name of Medication: _____

Reason for taking Medication: _____

Dose to be given at camp: _____

Route of Medication: _____

Frequency: _____ Date Ordered: _____

Duration of Order: _____ Quantity Received: _____

Expiration of Medications Received: _____

Special Storage Requirements: _____

Specific Directions (e.g., on empty stomach/with water): _____

Specific Precautions: _____

Possible Side Effects/Adverse Reactions: _____

_____ hereby authorize Extreme Destination Camp 2010
to administer, to my child, _____ the medication listed above.

Please provide a copy of medical card

Signature _____ DATE: _____