MEDICATION ADMINISTRATION FORM

If medication needs to be administered by the College's Health Services staff then this form must accompany the Health Form. All other non-prescription mediation must also be kept with the College's Health Services staff to be self-administered under supervision. Please put all medication into a zip lock bag with the child's name on it.

1. **To be completed by the Parent/Guardian:**

I give permission for the College's Health Services staff to administer medication to my child that his/her physician has approved/prescribed below. The medication will be given in the properly labeled original container from the pharmacy to the College's Health Services staff.

Signature of parent/guardian _____ Date _____

2. **To be completed by your child's Doctor:**

I request that the following patient receive the medication listed below.

Name of patient/camper _____ DOB _____
Diagnosis _____
Name of medication(s)
_____
Prescribed dose & means of administration
_____
_____
Time medication should be taken _____
Expected duration of treatment _____
Possible side effects & adverse reactions (if any)
_____
_____
Other recommendations (including PRN or self-administration orders)
_____
_____

Print name of Child's Doctor _____

Signature of Child's Doctor and Date _____

Address _____ Phone #_____

License #_____ DEA #_____