Medication Administration Authorization for Camp Spofford

Name_________________________________Age____ Date of Birth______________ WeekAttending______Cabin/Counselor_________

Parent's Signature: I give permission for authorized staff to administer the medications listed below and I verify that the camper has received the medications prior to entering camp:____Date___________

Medication Administration Instructions:

1. All Medications must be in the original container including vitamins and supplements (no loose pills or daily dispensers)
2. Place medications in a ziplock bag clearly labeled with full name and date of birth written in permanent marker on the outside.
3. Primary dispensing times for medications will be at meal times unless otherwise directed by a physician.
4. **Fill out Medications column only**; daily columns for administration use only.
5. If medication is As Needed, include the max dosage allowed in 24 hours.

Medications	Sunday ________	Monday ________	Tuesday ________	Wednesday ________	Thursday ________	Friday ________	Saturday ________
Name__________________________________ Strength_____________________Dose_______ Route_______Freq________________________ Reason_________________________________							
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Administrator Signature (____) ________________________ (____)__________________________ (____)____________________________

Updated 11/2018