SOLID ROCK
CAMP AND RETREAT CENTER

MEDICATION AUTHORIZATION FORM

*One form must be completed for **EACH** individual medication, **including over-the-counter medications**.* Form may be duplicated if needed.

This section is to be completed by the camper's physician prior to camp:

Camper's Name _____

Birthdate _____

Medication _____

☐ This is a controlled substance.

Dosage Route _____

Time of day medication is to be given: _____

Special Instructions: _____

Purpose of medication: _____

Possible side effects: _____

Start date _____ End date _____

_____
Signature of physician or person with prescriptive authority

_____
Printed name of physician or person with prescriptive authority

Phone Number _____Date _____

Note: All medication brought to Camp must be in **the original container** which clearly states the child's name, the health care provider, the name of the medication, date, time, and dosage. This form must be filled out completely in order for the medication to be given. **This applies to prescriptions as well as over-the counter meds.** All medications must be stored with Solid Rock Camp and Retreat Center's Medical Services personnel and may not be kept with the camper.

This section is to be completed by the camper's parent or guardian prior to camp:

Camper's Name _____

I hereby give my permission for _____
To take the medication listed on this form while at Solid Rock Camp and Retreat Center, as ordered by the health care provider. I understand that is is my responsibility to furnish this medication in the original container which clearly states the child's name, the health care provider, the name of the medication, date, time and dosage.

_____ I authorize Solid Rock Camp and Retreat Center's Medical Services personnel to inform the camper's counselor of this camper's medical need in regard to this medication.

_____ I do not authorize Solid Rock Camp and Retreat Center's Medical Services personnel to inform the camper's counselor of this camper's medical need in regard to this medication.

_____ I authorize my child to carry and use his/her own asthma inhaler while at camp.

_____
Signature of parent or guardian

_____
Name of parent or guardian

Phone #_____ Date _____

For Use by Camp Medical Services Personnel

Time	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.

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