MEDICATION AUTHORIZATION FORM

2728 Lower Twin Rocks Road, Florissant, CO 80816 **719-687-4184** **solidrockcampco.com**

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 for the medication to be given**. This applies to prescriptions as well as over-the counter meds, supplements, and vitamins.** All medications must be stored with Solid Rock Camp and Retreat Center's Medical Services personnel and may not be kept with the camper.

(Parents or guardians, you must complete the parent section on the second page of this form.)

Camper's Name _____ Birthdate _____

Camp Attending _____ Camp Dates _____

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

List all medications, including prescription and over-the-counter drugs, supplements, and vitamins.

Doctor's notes or special instructions

LIST Rx: *eg. Clarinex D tab*	↓CAMP PERSONNEL↓		SUN	MON	TUE	WED	THU	FRI
Med:								
Dosage:		8am						
Start Date: End Date:		12pm						
To Treat What?		6pm						
Contra indications:		9pm						

PRESCRIBING DOCTOR'S SIGNATURE:

x Date Phone ( )

Printed Name Address City State Zip

Additional medications may be listed on page 2 of this form.

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PRESCRIBING DOCTOR'S SIGNATURE:

x Date Phone ( )

Printed Name Address City State Zip

Use additional forms if necessary.

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 medications 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 these medications.

_____ 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

_____

Printed name of parent or guardian

Phone #_____ Date _____