

Medication Authorization Form for Student Camp

Students Name: _____ Sex: M ___ F ___ Date of birth: _____ Grade: _____

Allergies: _____

Medication Information

Medical condition for which medication will be required for student at camp:

Name of medication:

Prescription: _____ Over the counter: _____

Route to administer oral _____ topical _____ inhaled _____ IM: _____ Other: _____

Dosage: _____ Frequency: _____ Specific times (if needed): _____

Is this a new medication? Yes _____ No _____ If yes, the first dose must be administered at least 24 hours prior to check-in for camp

Special instructions: _____

Healthcare Providers Name (Print): _____ Phone Number: _____

Healthcare Providers Signature: _____ Date: _____

* Please indicate if the student is to self-carry this medication _____

Parent/Guardian Authorization

1. I permit my child's health care provider to be contacted for information regarding the administration of the medication listed on this form and authorize the medication listed above to be managed and given at student camp
2. I understand that medication not picked up at the end of camp with the student will be discarded
3. I understand that medication that is expired, not in original labeled packaging, or damaged will not be accepted

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____ Date: _____

Phone Number: _____

*Please submit this paperwork at least 1 week before Student Camp for review

*Authorization for medications must be completed and signed by a Florida licensed healthcare provider as per Florida Statutes 464. Medications not approved by the Food and Drug Administration (FDA) will not be accepted.