Medication Authorization Form for Student Camp

Student Name: _____Sex: M___F ___Date of birth: _____Grade: _____

Allergies: _____

Medication Information

For Provider Use:

Name of medication: _____ Indication: _____

Route: 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 Provider Name (Print):_____Phone Number:_____

Healthcare Providers Signature: _____Date:_____

* Emergency/Rescue medications student is to **self-carry**: Instructions: _____

Parent/Legal 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 the 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 its original labeled packaging, or damaged will not be accepted

Parent/Legal Guardian Name (Printed): _____

Parent/Guardian Signature: _____Date: _____

Phone Number: _____

*Authorization for medications must be completed and signed by a Florida-licensed healthcare provider (MD, DO, APRN, PA, DDS, DMD, DPM, OD) as per Florida Statutes 464.