Authorization for Administration of Medications
STAGE DOOR CONSERVATORY

Camp: ____

I, ________________authorize the administration of (name of medication) ____________

______________________ to (child's name)________________________________

for (reason) __________________________ by the Camp Director or a staff member

designated by the Camp Director.

Date medicine started: _________ Date medicine started at Camp: __________

Times of Administration:

1. ____________________________ 2. __________________________________

3. ____________________________ 4. __________________________________

Is refrigeration required? Yes ___ No ___ Special Instruction: _________________

____
(e.g. "Must be taken with food.")

Side effects: ____

____

Stop medication if the following reaction(s) observed: _________________________

____

Has this medication been prescribed by a physician: Yes ___ No ___

If yes, prescribing physician's name: ____________________ Phone: ____________

_____________________________ ________________________________
Parent/Guardian's Signature Date