

**THIS FORM ONLY NEEDS TO BE FILLED OUT AND SENT BACK IF CAMPER  
REQUIRES MEDICATION ON CAMPUS**



## **AUTHORIZATION FOR ADMINISTRATION OF MEDICATION**

All medications, both prescription and non-prescription, must be delivered to Hofstra Summer Camps along with this authorization form filled out by both the parent/guardian and by a licensed healthcare provider.

**Prescription medication must be in the original bottle with your child's name on it.**

**Campers are at NO time allowed to carry medication with them.**

### **TO BE COMPLETED AND SIGNED BY PARENT OR GUARDIAN:**

I request that my child (**Campers Name**) \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
receive the medication as prescribed on this form by our licensed health care provider. The medication is to be  
furnished by me in the properly labeled original container from the pharmacy. I understand that the camp nurse  
or other assigned person will administer the medication.

Signature (Parent/Guardian) \_\_\_\_\_ Date \_\_\_\_\_

### **TO BE COMPLETED AND SIGNED BY PROVIDER:**

#### **Recommendations and restrictions while at camp:**

Patient's Name \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Amount to be given: \_\_\_\_\_

Time to be given: \_\_\_\_\_

Side effects to report: \_\_\_\_\_

Side effects to expect: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Amount to be given: \_\_\_\_\_

Time to be given: \_\_\_\_\_

Side effects to report: \_\_\_\_\_

Side effects to expect: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Amount to be given: \_\_\_\_\_

Time to be given: \_\_\_\_\_

Side effects to report: \_\_\_\_\_

Side effects to expect: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Amount to be given: \_\_\_\_\_

Time to be given: \_\_\_\_\_

Side effects to report: \_\_\_\_\_

Side effects to expect: \_\_\_\_\_

#### **Provider Information:**

Signature: \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_

#### **Provider Stamp:**

Date of form  
completion \_\_\_\_\_