PARENT AND PROVIDER AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION AT CAMP

Alexandria Soccer Camps requests that all medications that can be taken prior to or after the camp day be administered at home. The following information is for medications that must be given during the camp day **by the camp director or designated lead staff.**

To be completed by the parent or guardian

I request that my child _____DOB _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

Signature (Parent or Guardian): _____

Telephone: _____ Home Work: _____

*Medication must be in original pharmacy labeled container with specific orders and name of medication. Medication and refills must be brought to camp by parent, guardian or responsible adult.

To be completed by physician

I request that my patient, as listed below, receive the following medication:

Name of Child _____ DOB _____

Diagnosis: _____

Medication	Dosage	Frequency / Time To Be Taken	Route of Administration

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any)_____

_____

❏ Patient has a life-threatening condition and should be permitted to self-carry and self-administer medication.

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

Plan reviewed with parent(s)/guardian(s):

Parent Signature: _____ Date: _____

Nurse Signature: _____ Date: _____