

**MOSES BROWN SCHOOL  
SUMMER CAMP  
MEDICATION AUTHORIZATION**

CAMP SEASON YEAR: \_\_\_\_\_

NAME: \_\_\_\_\_ GRADE: \_\_\_\_

**To be completed by physician or authorized provider**

Medication: \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Time: \_\_\_\_\_

Duration of order: From: \_\_\_\_\_ To: \_\_\_\_\_

**Diagnosis/Reason for medication:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Restrictions and/or side effects:** \_\_\_\_\_

**SPECIAL REQUIREMENTS**

This student may carry and/or self-administer this medication:

Yes \_\_\_\_\_ No \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**To be completed by parent/guardian:**

I request that my child be given the above medication at camp or be permitted to self-carry/self-medicate as authorized by my physician and according to school policy.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_