AUTHORIZATION TO ADMINISTER MEDICATION

Prescriber Form

This order is only valid for Summer of 20_____

Camp(s) child will attend:____

This form must be completed fully and annually for *all medications* and each time there is a change in dosage, frequency, or time of administration of a medication in order for Cranbrook to administer the medication. A prescriber's signature must be on this form for self-carry medications or medications without the original container.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- Please check expiration dates of medications prior to bringing them to camp.
- An adult must bring the medication to the camp and hand it directly to a camp staff member accompanied by this form.
- The camp nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

PRESCRIBER'S AUTHORIZATION (*this section to be completed by the prescriber*)

Name of Camper: ____ Date of Birth: _______________ Grade: ________

Condition for which medication is being administered: ____

Medication Name: ____________________________________ Dose: ______________ Route: ________ Expiration Date: _________

Time/frequency of administration: _________________________ if PRN, frequency: ____

If PRN, for what symptoms: ________________________________ Relevant side effects, specify if any: _________________________

Medication shall be administered from _______________ to _______________
Month/Day/Year Month/Day/Year

Additional Medication (if applicable):

Condition for which medication is being administered: ____

Medication Name: ____________________________________ Dose: ______________ Route: ________ Expiration Date: _________

Time/frequency of administration: _________________________ if PRN, frequency: ____

If PRN, for what symptoms: ________________________________ Relevant side effects, specify if any: _________________________

Medication shall be administered from _______________ to _______________
Month/Day/Year Month/Day/Year

Prescriber's Name/Title: ____

Telephone: ________________________ Fax: _____________________________

Address: ____

Prescriber's Signature: ____
(Original signature or signature stamp only)

Use for prescriber's address

PARENT/GUARDIAN AUTHORIZATION *(this section to be completed by the parent/guardian)*

I/We request camp personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the camper named above, including the administration of medication at camp. I/We understand that at the end of camp, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the camp nurse to communicate with the healthcare provider as allowed by HIPAA.

Parent/Guardian Signature: ____ Date: ____________________

Home Phone #: _______________________ Cell Phone #: ________________________ Work Phone #: _________________________

SELF-CARRY/SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of medication (including **emergency medication**) may be authorized by the prescriber and must be approved by the camp nurse according to the School Nurse Program medication policy.

This camper is both capable and responsible for self-administering this medication: ____ NO ____Yes, Supervised ____Yes, Unsupervised

Prescriber's authorization for self carry/self administration of medication: ____
Signature Date

Order reviewed and approved by the camp RN: ____ **Date:** _________________