

Authorization to Administer Medication at Camp Harmony

Name of Child: _____

Name of Medication: _____

Dosage & Frequency: _____

Directions: _____

Purpose of Drug: _____

Any possible side effects: _____

Signature of Physician

Signature of Parent

Date

Address

Phone

- Please return completed form to the Camp Harmony Nurse.
- You may FAX to (732)469-9444.
- Additional copies of this form available at www.campharmony.com