



Kitsap Forest Adventure Camp

play ★ explore ★ create

Authorized Prescriber's Order for Medication Administration

Authorized Prescriber's Order

(Physician, Dentist, Physician's Assistant, Advanced Practice Registered Nurse)

PRESCRIPTION MEDICATION PERMISSION – for all prescription medications, including controlled, non-controlled and self-administered medications

Child's Name _____ Birth Date _____ Today's Date _____

Medication Name _____ Controlled Drug? **Yes / No**

Condition for which drug is administered _____

Dosage _____ Method _____ Times of Administration: _____

Any Specific Instructions for medication Administration: _____

Medication Administration: Start Date _____ Stop Date _____

May this medication be self-administered by the child? **Yes / No**

Relevant Side Effects of Medication _____

Plan for management of side effects _____

Known Camper Allergies _____

Prescriber Information & Signature

Printed Name _____ Phone: _____

Address (Street, City, State, Zip) _____

Prescriber signature: _____ Date: _____

Parent/Guardian Information & Signature

Authorizing administration of medication as described and directed above

Printed Name _____ Phone: _____

Address (Street, City, State, Zip) _____

Parent/Guardian signature: _____ Date: _____

Camper Name: _____

