Medication Authorization Form

Camper Name:_____ Camper Date of Birth_____

Name of Medication(s):

_____

_____

_____

Reason for Medication (If for an allergy, please list symptoms as well):

_____

_____

_____

Instructions for administration of medication (day/time to give medication, dosage, etc.):

_____

_____

_____

Authorization is effective from: (start date) _____to_____(end date)

Parent/Guardian Signature:_____Date:_____

Below is for XL Staff use only:

Staff Name	Date	Name of Medication	Dosage	Time