

Medical Administration Form

(Camper's Full Name) Camp Funtastic Medical Administration Form 2024

(FORM MUST BE FULLY COMPLETED.)

The Parent/Guardian of		asks that Camp Funta:	stic Staff give the	
following medication(Name &	Dosage Amount)	to my (child, according to the	
Health Care Provider's signed instruct				
Camp Funtastic agrees to administ parent/guardian's responsibility to unused medication within one wee	furnish the medication	_	=	
Prescription Medication: Prescriptio medicine, time medicine is to be giv provider's name. Pharmacy name and	en, dosage, and date med	icine is to be stopped ar		
Over the Counter Medication: Over match the signed health care provide			9	
By signing this document, I give per the administration of this medication	-	=		
Parent/Legal Guardian's Name	 Parent/Lega	Parent/Legal Guardian's Signature		
Work Phone	Home Phone		Cell Phone	
HEATH CARE PROVIDER AUTH	ORIZATION TO ADMINIS	TER MEDICATION AT CA	AMP FUNTASTIC	
nild's Name:		Birthdate:		
Medication:		<u> </u>		
Oosage:		Route:		
To be given at the following time(s): _				
Special Instructions:				
Purpose of Medication:				
Side effects that need to be reported:				
tarting Date:		Ending Date:	Ending Date:	
Signature of Health Care Provider with Prescriptive Authority		License Numbe	License Number	
Phone Number		Date	 Date	

Please ask the pharmacist for a separate medicine bottle to keep at Camp Funtastic. Thank you!