PATIENT NAME:_____

DOB:_____

HEALTHCARE PROVIDER AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION AT CAMP SONLIGHT

This form must be completed in its entirety and signed by your child's medical provider in order for prescription medications to be continued while at camp.

Medication:
Dosage:
Time:
Reason for taking:

Medication:
Dosage:
Time:
Reason for taking:

Medication:
Dosage:
Time:
Reason for taking:

Medication:
Dosage:
Time:
Reason for taking:

Medication:
Dosage:
Time:
Reason for taking:

Medication:
Dosage:
Time:
Reason for taking:

Medication:
Dosage:
Time:
Reason for taking:

PROVIDER PRINTED NAME:

_____

PROVIDER SIGNATURE:_____**DATE:**_____