UCPNB
Valley of the Moon Camp 2012
Medication Authorization Form
June 1-3, 2012

Camper Name: _____

Allergies: _____

Do you Self-Administer your Medication?
❑ Yes ❑ No

If **YES**, you will be responsible for holding and administering your medication(s). Please fill out the medication information below for our records, in case of emergency.

If NO, please fill out the information below.

Medication	Dosage	Time	Special Instructions

Prescription and over-the-counter medications should be clearly marked containers (original containers preferred) listing name of person receiving medication, name of medication, dosage and time it is to be dispensed. Doctor's name should also be listed on any prescription medications. Please include directions regarding how to administer medications, side affects or restrictions associated with the medication.

I hereby authorize UCPNB Staff Nurse to administer the indicated medication/s to _____
At the prescribed time and in the prescribed dosage.

_____
Camper Signature Date

_____
Conservator (if applicable) Date