

# Camp Hope

*Romans 12:12-13*

## AUTHORIZATION FOR ADMINISTRATION OF MEDICATIONS FOR A SPECIFIC CAMPER

I hereby authorize the qualified health supervisor who is a Qualified Medications Administration Personnel (QMAP) to administer prescribed medication

to \_\_\_\_\_ while he/she is attending camp.  
(camper)

Date Prescribed	Medication Name	Directions

In addition to the above scheduled medications I authorize the QMAP to administer the following over the counter medications:

<u>Medication</u>	<u>Directions</u>	<u>Indications for Use</u>
Tylenol 325-500 mg tabs	one or two every 4 hrs	Headache or pain
Benadryl 25mg caps	one or two every 2-4 hrs	Mild allergic reactions
Hydrocortisone Topical cream/ointment	as directed on package	Rash/itching
Neosporin Cream	as directed on package	as needed for first aid
Allergies: _____ (including food or medication allergies.)		

Signature of Physician: \_\_\_\_\_

Signature of Parent: \_\_\_\_\_

Office Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date: \_\_\_\_\_

**All prescriptions must be in original prescription bottle with original prescription label, including inhalers.**