



### MEDICATION ADMINISTRATION FORM

*One form per medication. Medication cannot be administered until the information below is completed*

Child Name (First and Last) \_\_\_\_\_ Date of Birth \_\_\_\_\_

#### MEDICATION INFORMATION

Name of Medication \_\_\_\_\_

Dose \_\_\_\_\_ Route \_\_\_\_\_ Does the medicine need to refrigerated? YES NO

Reason for medication \_\_\_\_\_

Date to start medication \_\_\_\_/\_\_\_\_/\_\_\_\_

Stop date \_\_\_\_/\_\_\_\_/\_\_\_\_

Time(s) of medication administration \_\_\_\_\_

Additional instructions \_\_\_\_\_

Known side effects of medicine \_\_\_\_\_

Plan of management of side effects \_\_\_\_\_

Child allergies \_\_\_\_\_

#### PRESCRIBER'S INFORMATION

Prescriber's Name \_\_\_\_\_ Prescriber's Phone \_\_\_\_\_

Prescriber's signature \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_

I hereby give permission for the camp program to administer medicine as prescribed above. **I also give permission for BPRW staff to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

\_\_\_\_\_  
Parent/ Guardian Name (Print)

\_\_\_\_\_  
Parent/ Guardian Signature

Phone \_\_\_\_\_