

Woodstock Day School Summer Adventure  
**Parent & Prescriber's Authorization for  
Administration of Medication  
During Camp Hours**

Authorization for Administration of Medication

**A. To be completed by the Parent or Guardian:**

I request that my child \_\_\_\_\_, grade \_\_\_\_\_, receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that a school-designated person will administer the medication.

Signature (parent or guardian): \_\_\_\_\_ Date \_\_\_\_\_

**B. To be completed by the Licensed Health Care Prescriber:**

I request that my patient receive the following medication, as listed below:

Name of student: \_\_\_\_\_ DOB \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of medication(s): \_\_\_\_\_

Prescribed dose & means of administration: \_\_\_\_\_

Time medication should be taken: \_\_\_\_\_

Expected duration of treatment: \_\_\_\_\_

Possible side effects & adverse reactions (if any): \_\_\_\_\_

Other recommendations (including PRN or self-administration orders): \_\_\_\_\_

Name/Title of Licensed Prescriber (Please Print): \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_ Tel. Number: \_\_\_\_\_