2026 Medication Authorization Form

PHYSICIAN'S SECTION

Camper's Name: _____

Date of Birth: _____

This Medication Authorization form **MUST BE COMPLETED** in order for the camp staff to dispense over-the-counter, non-prescription medications and/or prescription medications to the camper, as per the Rockland County Health Department.

Prescription medication can only be administered when it is in a **pharmacy labeled bottle accompanied** by a **doctor's prescription of instruction** and a **parent's note of permission.**

Over-the-counter medication must be in its original container accompanied by a **parent's note of permission** Indicating dose and time medication is to be administered.

EPI PEN:

Does this camper require an EPI PEN? Yes_____ No_____

Condition: _____

INHALER:

Does this camper require an inhaler? Yes_____ No_____

Condition: _____

OTHER MEDICATIONS:

Does your camper take either over-the-counter or prescriptions medication on a routine basis?

Yes_____No _____

Please list all medications your camper currently takes:

CHECK HERE IF MEDS NEED TO BE TAKEN AT CAMP

Med. #1 _____ Reason for taking: _____ ☐

Med. #2_____ Reason for taking: _____ ☐

Med. #3_____ Reason for taking: _____ ☐

Physician's Signature: _____ Date: _____

Physician's Address:_____

Physician's Telephone: _____ Physician's Fax: _____