



Medication and reason for use <i>(Example: Amoxicillin for ear infection)</i>	Dosage and frequency <i>(Example: 1 tablet, 3x/day)</i>	Check all that apply
	<input type="checkbox"/> Prescription <input type="checkbox"/> Non	<input type="checkbox"/> 8:30 AM (or _____) <input type="checkbox"/> 1:00 PM (or _____) <input type="checkbox"/> 6:30 PM (or _____) <input type="checkbox"/> 9:00 PM (or _____) <input type="checkbox"/> As Needed
	<input type="checkbox"/> Prescription <input type="checkbox"/> Non	<input type="checkbox"/> 8:30 AM (or _____) <input type="checkbox"/> 1:00 PM (or _____) <input type="checkbox"/> 6:30 PM (or _____) <input type="checkbox"/> 9:00 PM (or _____) <input type="checkbox"/> As Needed
	<input type="checkbox"/> Prescription <input type="checkbox"/> Non	<input type="checkbox"/> 8:30 AM (or _____) <input type="checkbox"/> 1:00 PM (or _____) <input type="checkbox"/> 6:30 PM (or _____) <input type="checkbox"/> 9:00 PM (or _____) <input type="checkbox"/> As Needed

All prescription medications MUST be in correctly labeled container with name and dosage.

If your child's name is not on your non-prescription container, please write their name on it.

Health Care Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Telephone: \_\_\_\_\_

“I request the authorized camp staff to administer the medication or supervise the camper in self-administration if authorized by the above prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at Camps operated by GSCSA. I understand that at the end of the authorized period, an adult MUST pick up the medication, otherwise it will be discarded.”

Parent/guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_

For additional medications, attach a second copy of this form.