CREATIVE ARTS at PARK

Physician/PCP Form

LICENSED PRESCRIBER'S ORDERS
CONCERNING THE ADMINISTRATION OF MEDICATION BY CAMP PERSONNEL

Name of Child_____Sex[ ] Date of Birth_____School_____ Grade_____

Address_____ Phone _____

Name of Licensed Prescriber _____Business Phone _____

Address_____ Emergency Phone _____

Medication_____ Dosage _____

Frequency_____Time(s) of Administration_____
(Note: *whenever possible, medication should be scheduled during non-school hours.)*

Start Date_____ Discontinuation Date_____

Specific directions or information for administration_____

Side effects, contraindication, adverse reactions to be

observed_____

YES NO

____ ____ Child may self-administer asthma and/or emergency allergic medication if the Camp Nurse determines it safe and appropriate.

Date of next scheduled visit_____

Diagnosis*_____

Other medical conditions*_____

Currently receiving these additional medication(s)*_____

Signature of Licensed Prescriber _____ Date_____

*If not in violation of confidentiality.

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