

# Medication Form

(FOR SEVERE ALLERGY, PLEASE USE  
MEDICATION & ALLERGY ACTION PLAN FORM)

**ALL MEDICATIONS, PRESCRIPTION AND NON-PRESCRIPTION, REQUIRE THE WRITTEN PERMISSION OF THE PARENT/GUARDIAN AND THE PHYSICIAN BEFORE THEY WILL BE ADMINISTERED. MEDICATIONS MUST BE BROUGHT TO CAMP BY THE PARENT/GUARDIAN AND PICKED UP AT THE END OF THE CAMP SESSION OR THE END OF THE PERIOD OF ADMINISTRATION.**

Camper Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Division/Group: \_\_\_\_\_

**Permission is granted for Ivy League Day Camp personnel to administer the following medication.**

Medication Name: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time/Length: \_\_\_\_\_

Reason for Administration:

\_\_\_\_\_  
\_\_\_\_\_

Possible Side Effects:

\_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: (Please print/stamp) \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_