CAMP APOLLO

***Please return by March 1 to*:**
CAMP APOLLO
Post Office Box 34
Plainview, NY 11803

H-3

STAFF

REQUEST FOR ADMINISTRATION OF MEDICATION-2019

This form and/or the as needed medication form must be filled out for all medications that are to be administered at camp.

I give permission for my child _____ to receive medication during camp
Last Name, First Name

hours as instructed by my physician.

_____ _____ _____
Signature Relationship Date

TO BE COMPLETED AND SIGNED BY PHYSICIAN

Medication: _____ Purpose: _____

Dosage: _____Route: _____ Time of Day: _____

Special Instructions: _____

Possible Side Effects_____

_____ _____
Signature of Physician Date

TO BE COMPLETED AND SIGNED BY PHYSICIAN

Medication: _____ Purpose: _____

Dosage: _____Route: _____ Time of Day: _____

Special Instructions: _____

Possible Side Effects_____

_____ _____
Signature of Physician Date