



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

H-3

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
 Camper's 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