RAYS OF HOPE
BEREAVEMENT CAMP
PHYSICIAN MEDICATION ORDER FORM

This form is to be filled out by the parent/guardian, signed by the physician ordering medication and returned to "Rays of Hope" Bereavement Camp.

The following medications must be given during camp: *The first dose of any new medication must be administered at home.*

Name of Camper: _____

Medication/Dosage Time(s) to be given:

1._____

2._____

3._____

Please indicate if medication must be taken with water, milk, food, etc._____

_____

For medications listed above, list all side effects which should be observed by camp personnel.

1._____

2._____

3._____

List any reasons for not giving medications at the prescribed time (vomiting, fever, drowsiness, and seizures:

_____

Date: _____ Physician Signature: _____

Address: _____

Phone: _____

Parental Authorization:

I/We authorize "Rays of Hope" Bereavement Camp to administer the medication(s) prescribed by our physician, and in so doing relieve the camp, its agents or representatives of any responsibility for ill effects which may result from the administering of said prescribed medications per the physician directions listed above.

Date: _____ Signature of parent/guardian: _____