Buckingham Browne & Nichols
Summer Camp Medication Order

*Student Name*_____ *Birth Date*_____ *Grade*_____

*Address*_____

*Name of Licensed Prescriber*_____

*Address*_____

Telephone _____ *Fax*_____

Medication: _____

*Dosage:*_____ *Frequency:* _____ *Route:* _____

Specific Directions: _____

Expected Action: _____

Possible Side Effects/Adverse Reactions: _____

*Significant Medical History*_____

- *Consent of self-administration (provided the nurse determines it is safe and appropriate)*

  *Yes*_____ *No*_____

Valid for one year from date below

Optional Information

- *Other daily medications*_____
- *Date of next scheduled visit to prescriber*_____

_____*Date*_____

Signature of Licensed Prescriber

This form is to be completed by a Licensed Provider: Physician, Nurse Practitioner, Dentist
as authorized by Ch. 94C