NEW

DAY CAMP AUTHORIZATION FOR MEDICATION AND TREATMENTS

Mandatory return to Linda Apel by May 9th. Fax : 1-877-913-1293 Email PDF: linda.apel@steppingstonesohio.org

CAMPER NAME _____ AGE _____

To be filled out by nursing staff.

Medication Name	Dosage (mg)	Amount (# of tabs / ml)	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

TREATMENT	APPLICATION	Time																																

Meds taken by: (please check one) ___ mouth ___tube ___with applesauce/pudding ___water

I request the the Camp Nurse dispense the above medications and/or perform the above treatments for my child as directed by his/her physician.

Parent/Guardian Signature_____ Phone Number _____ Date ____/____/____

*Please note that if your camper does not require a routine medication or treatment while at camp, this form is not required.

Mail: Stepping Stones
5650 Given Rd.
Cincinnati, OH 45243