



Epipen Authorization Form

Part 1: To be completed by the Parent/Guardian

Name of Camp: **“Monadnock Christian Ministries”**

Child's Name: _____

Camper's DOB: _____ Biological Sex: _____

Physician's Name: _____

Physician's Address: _____

Telephone (business): _____

Telephone (emergency): _____

“I request that my child be assisted in taking the medicine(s) described below at camp by authorized persons or permitted to medicate her/himself as also authorized by me and my physician.”

Parent's Name (print): _____

Signature of Parent: _____

Date: _____



Part 2: To be completed by the Physician

Diagnosis: _____

Date of Order: _____

If Medicine is to be given when needed, describe indications:

List significant side effects/adverse reactions:

Medication(s):

Form:

Route:

Dose:

Time interval for repeating dosage:

List any severe adverse reactions that may occur to another child, for whom the epinephrine auto-injector is not prescribed, should such an individual receive a dose of the medication:

____ I believe this individual has received adequate information on how and when to use an epipen, and that he/she can use it properly.

Please Specify Their Name:

____ I believe the name individual is to carry an epipen during their stay at summer camp (an additional epipen is to be kept in the camp health center during their stay)

-OR-

____ The epipen will be kept in the camp health center or other appropriate location

Other Information: _____

Physicians Signature: _____ Date: _____