



Inhaler Authorization Form

Part 1: To be completed by the Parent or Guardian

Name of Camp: **"Monadnock Christian Ministries"**

Child's Name: _____

Camper's D.O.B: ____/____/____ 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 Inhaler 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 Inhaler, and that he/she can use it properly.

Please Specify Their Name:

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

-OR-

___ The Inhaler will be kept in the camp health center or other appropriate location

Other Information: _____

Physicians Signature: _____ Date: _____