OCCOHANNOCK ON THE BAY CAMP AND RETREAT CENTER
Supplemental Medication Authorization/Parent Consent Record

Medication Authorization
(For Use By Licensed Prescriber ONLY

Date of Order:_____

Occohannock on the Bay Camp and Retreat Center

Name of Camper:_____ DOB:_____

Camper's Diagnosis:_____

Medication:_____

Dosage:_____

Time of Administration:_____ Duration of order:_____

Possible Side Effects:_____

Licensed Provider's Name:_____
Please Print

Licensed Provider's Signature:_____

Telephone:_____

Parent/Guardian Consent

I request that Occohannock on the Bay Camp and Retreat Center give the above medication (s) as ordered by the licensed provider. I also give permission for the Health Coordinator to contact the above licensed provider regarding the administration of this medication.

_____ Date:_____
Signature Parent/Legal Guardian

Occohannock on the Bay Camp and Retreat Center
9403 Camp Lane
Belle Haven, VA 23306
Office: (757) 442-7836
Fax: (757) 442- 3030