Physician Request for Administration of Medication
Tipp Monroe Community Services / Camp Kern

PHYSICAN MUST COMPLETE THIS SIDE OF THE FORM

Patient Information:

Name: _____Age _____ ☐ Female ☐ Male

Address: _____

ALLERGIES: ☐ YES ☐ NO

PLEASE LIST ALL ALLERGIES: _____

?????Since medications for this camper cannot be scheduled outside of Camp Kern hours, the administration of medications may be supervised by medically untrained personnel.
It is requested that the medications listed below be administered by the Tipp Monroe Community Services volunteer nurse.

Name of Drug	Dosage	Time	Route/Method	Begin Date	End Date	Possible Reactions/Special Instructions

If medication is an ASTHMA INHALER, please complete the following:

- Must the child carry and self-administer the asthma inhaler: YES NO
- Procedure to follow in the event that the medication does not produce the expected relief from the child's asthma attack:
- Adverse reactions for unauthorized user of asthma inhaler.

Physician's Signature: _____

Physician's Address: _____

Physician's Phone: _____ Date of this request: _____