

**ALEOOP - MEDICATION FORM -  
For Authorization for Medication to be  
Administered During ALEOOP  
Only for children requiring any medication during camp**



- ☒ It is necessary for you and your child’s physician to complete this form for **each** medication required during camp, prescription or over-the-counter. In accordance with our policy on medication administration, this completed form will permit the camp nurse to give your child medication(s) as directed.
- ☒ This form must be delivered by parent/caretaker with medication(s) to the nurse on the first day of ALEOOP. Medication of any type cannot be given by the nurse without physician authorization; therefore no medication will be accepted without the completed paperwork.
- ☒ All medication will be kept in the nurse’s office unless your child’s physician specifically authorizes him/her to carry and self-administer an EpiPen or an Asthma inhaler.

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This section is to be completed by the **Parent**:

Child’s Name \_\_\_\_\_  
Last
First
Date of Birth

I request that my child be assisted in taking the medication described below at camp or permitted to self-medicate as authorized by my physician.

\_\_\_\_\_  
Date
Parent/Guardian Signature
Home Phone

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The following section is to be completed by the **Physician**:

Diagnosis for which medication is given: \_\_\_\_\_  
 If allergy, please be specific: \_\_\_\_\_  
 Name of medication: \_\_\_\_\_  
 Form and Dose: \_\_\_\_\_  
 Timing: \_\_\_\_\_  
 List significant side effects: \_\_\_\_\_  
 Activity restrictions: \_\_\_\_\_

**Asthma Inhalers:**

\_\_\_\_ I have instructed the above student in the proper way to self-administer his/her Asthma inhaler. It is my professional opinion that he/she understands how and when to use the inhaler and **should be** allowed to carry and use it as needed.

\_\_\_\_ It is my professional opinion that the above student **should not** carry and self-administer his/her Asthma inhaler.

**EpiPens:**

\_\_\_\_ I have instructed the above student in the proper way to self-administer his/her EpiPen. It is my professional opinion that he/she understands how and when to use the EpiPen and **should be** allowed to carry and use the EpiPen as needed.

\_\_\_\_ It is my professional opinion that the above student **should not** carry and self-administer his/her EpiPen.

\_\_\_\_\_  
Date
Physician Signature
Office Stamp