Camp Huckins Health Center

Medication Order Form

To be completed by a licensed prescriber
(one medication per form please)

Name of Camper_____
Date of Birth _____

Name of Licensed Prescriber_____
Practice Name_____
Business Phone_____

Diagnosis _____
Medication_____
Dose _____
Route of administration_____
Frequency_____
Time(s) of Administration
(breakfast, lunch, dinner, or bedtime)_____

Signature of Licensed Prescriber_____
Date _____