MEDICATION AUTHORIZATION

Prescriptions without Pharmacy Label

PATHFINDER RANCH
outdoor education • summer camp • conferences & retreats

PATIENT INFO

LAST Name: _____ FIRST Name: _____

Date of Birth: _____ Outdoor Science ☐ Summer Camp ☐ Other: _____

- This form must be completed for any Prescription Medications which lack sufficient patient information (i.e. Name, Dosage,Frequency, Prescribing Physician, etc.) and are to be administered by authorized Pathfinder Ranch personnel
- If the Prescription Medication is in its original container and has the prescription label attached, this form is NOT needed

MEDICATION NAME:

Amount (to be given): _____

☐ By Mouth
☐ Topically
☐ Inhalation
☐ Intranasal Spray
☐ Injection

Time(s) & Frequency: _____

Administer as needed ☐

MEDICATION NAME:

Amount (to be given): _____

☐ By Mouth
☐ Topically
☐ Inhalation
☐ Intranasal Spray
☐ Injection

Time(s) & Frequency: _____

Administer as needed ☐

MEDICATION NAME:

Amount (to be given): _____

☐ By Mouth
☐ Topically
☐ Inhalation
☐ Intranasal Spray
☐ Injection

Time(s) & Frequency: _____

Administer as needed ☐

If room is needed for additional medications, please attach additional pages

PHYSICIAN'S INFO

Printed NAME: _____

Signature*: _____

Date: _____ Phone: _____

* By signing this form, I state that I understand that authorized Pathfinder Ranch Health Center personnel will be administering these medications or supervising the patient in self administration. I certify that I have legal consent to medical treatment for the child named above

Physician's Stamp

For any questions, please contact the Pathfinder Ranch Health Center via PHONE: (951) 659-2455 ext. 22 or FAX: (951) 659-0351