

**Date:** [Insert Date]

**To:** [Camp Name] Health Center / Camp Nurse

**RE:** Pediatric Weight-Based Medication Authorization

**Camper Name:** [Insert Full Name]

**Date of Birth:** [Insert Date of Birth]

**Current Weight:** [Insert Weight] [lbs/kg] as of [Insert Date]

To Whom It May Concern,

I hereby authorize the trained medical staff at [Camp Name] to administer the following medication(s) to my child based on their current weight in the event of illness or injury during the camp session.

<b>Medication Name</b>	<b>Indication (e.g., Fever, Pain, Allergy)</b>	<b>Dosage (mg/kg or specific ml/mg)</b>	<b>Frequency / Max Dose</b>
[e.g. Acetaminophen]	[e.g. Pain/Fever]	[Insert Dose]	[Insert Instructions]
[e.g. Ibuprofen]	[e.g. Inflammation]	[Insert Dose]	[Insert Instructions]

**Known Allergies:** [List allergies or write NONE]

**Physician Authorization:**

Physician Name: [Insert Name]

Clinic Name: [Insert Clinic]

Phone Number: [Insert Phone]

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian Consent:**

I confirm that the weight provided is accurate and I give permission for the dosage above to be administered to my child by camp health staff.

Parent Name: [Insert Name]

Emergency Phone: [Insert Phone]

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_