CAMP WRIGHT

Date_____

_____

_____

_____

Phone: _____ Fax: _____

Dear Doctor/Health Care Provider,

Your patient _____ (DOB____/____/____) is a camper at Camp Wright. They came to camp with the medication(s) listed below and do not have an order for the administration of the medication(s).

Even if the medication is OTC and/or not listed on the camp standing orders, the Maryland Board of Nursing requires a signed order for any medication and/or treatment to be administered at camp.

Please review and sign the following if acceptable:

Medication_____
Dosage_____
Route_____
Time_____

Medication_____
Dosage_____
Route_____
Time_____

Medication_____
Dosage_____
Route_____
Time_____

Medication_____
Dosage_____
Route_____
Time_____

_____ _____
Doctor/Health Care Provider Signature Date

Please call me with any questions or concerns. Thank you for your attention to this matter.

Sincerely,

Camp Nurse
Phone 410-643-4171
Fax 410-643-8421