

REQUEST FOR THE ADMINISTRATION OF MEDICATION BY DAY CAMP PERSONNEL

This form must be completed as outlined below:

Section I: Physician's Instructions

Name of Child _____ is under my care and should receive (name of medicine/vitamin) _____ (dosage) _____, as follows _____ the instructions for administration. Possible side effects to watch for: _____. Expiration date (may not exceed six months from date of this request if prescribing medication or food supplement): _____

Name of Physician: _____	Telephone Number: _____
Physician's Signature: _____	Date: _____

Note: If medication or Vitamin is a prescription from pharmacy, physician's instructions and signature will not be required. Instead of having the above section completed, the parent/guardian completes the chart below:

Rx Number: _____	Pharmacy: _____
Pharmacy Address: _____	Telephone Number: _____

Section II: Parent/Guardian Request for Administration of Medicine. Hereby request and give permission to the administrator or his delegate to administer the following medication, vitamin, or special diet to my child:

Signature of Parent/Guardian: _____	Date: _____
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Section III: Medication Given by Day Camp Personnel:

(Name of Child) _____ was given (medicine, vitamin, or special diet): _____ (dosage) _____ at the following time(s) on the following date(s): _____

Date of Dosage	Amount & Time	Signature of Administrator

