Star Hill Family Athletic Center

2011 Summer Recreation Program

Authorization for the Administration of Medication

Name of Child ______________________ Date of Birth ____/ ____/ ____ Today's Date ____/____/____

Medication Name ____ Controlled Drug? ☐ YES ☐ NO

Dosage ___________________ Method ___________________ Time of Administration ________________

Specific Instructions of Medication Administration ____

Medication Administration: Start Date ____/ ____/ ____ Stop Date ____/ ____/ ____

Is this Medication to be self-administered by the child? ☐ YES ☐ NO

Relevant Side Effects of Medication ____

Plan of Management for Side Effects ____

Known Food or Drug Allergies? ☐ YES ☐ NO Reactions to? ☐ YES ☐ NO

Interactions with? ☐ YES ☐ NO

If "yes" to any of the above, please explain ____

Prescriber's Name ____ Phone Number (____) ______________

Prescriber's Address ____ Town ____________________

Prescribers Signature ____

Parent/ Guardian Authorization:

I request that medication be administered to my child as described and directed above.

Name of Camp ____ Today's Date ____/ ____/ ____

Child's Name _______________________ Address _________________________ Town _______________

Name of Parent/Guardian Authorizing Administration of Medication as described and directed above:

First Name _________________________ Last Name _________________________

Relationship to Child: ☐ Mother ☐ Father ☐ Guardian/Other explain: ______________________

Address ______________________________ Town _______________ Phone Number (____) __________

Signature of Parent/ Guardian Authorizing Administration of Medication ___________________________

Name of Camp Personnel Receiving Written Authorization and Medication _____________________

Title/ Position ______________________ **Signature (in ink)** ____________________________________