

MEDICATION FORM ~ AN ATTACHED PHOTO OF YOUR CHILD IS RECOMMENDED

Name of child: _____ Name of Youth Program: _____

Dates of program: _____

Name of child: _____

Address: _____ DOB: ____ / ____ / ____

Condition for which drug is being administered: _____

MEDICATION NAME: _____ Controlled Drug: YES OR NO

Dose to be administered: _____ Method: _____

Time(s) of administration: _____

Relevant side effects to be observed; if any: _____

Plan of management for side effects: _____

Other instructions for administration: _____

Length of time which medication will be administered: Dates ~ FROM _____ TO _____

Known Food or Drug Allergies: _____

NAME OF PRESCRIBER: _____ Date: _____

Address: _____ Phone number: _____



PRESCRIBER'S SIGNATURE: _____

AUTHORIZATION OF PARENT/GUARDIAN (Administration of above medicines by program personnel)

To: Middletown Recreation _____ Date: _____

I hereby request that medication be administered to my child as described and directed above. I acknowledge that said medication may be administered by trained camp personnel as opposed to medical personnel and I also understand that any medical information regarding my child's well-being will be shared with staff.

Printed Name _____ Relationship to child _____



PARENT'S SIGNATURE: _____

SIGNATURE OF PARENT/GUARDIAN AUTHORIZING ADMINISTRATION OF MEDS