# PHYSICIAN & PARENT AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE

**To administer any medication, physician prescribed or over the counter medications, a physician's signature is required.**

The following information is necessary for any participant to possess or use prescribed medications or treatments or non-prescription medication during Avon Lake Summer Camp. I hereby request and give permission to designated personnel to help in the self-administration of medication to my child. In the event of an emergency, staff will be authorized to administer medication unless otherwise noted on this form.

Camper's Full Name: _____ Date of Birth: _____ / _____ / _____

I am sending medication in the original contained from our physician or pharmacist (Please send only the medicine that your child currently needs and place medication container in a Ziploc bag, labeled with your child's name.

I understand and acknowledge that such assistance may be rendered by an employee of the program who is not medically trained. There will not be any designated personnel available for procedures for which specific medical training is necessary. I hereby release and hold harmless Avon Lake, its officials, employees, agents and representatives from any and all claims, costs, damages and liabilities directly or indirectly resulting from this assistance. I agree to submit a revised signed statement if this information should change at any time before or during summer camp.

Please list the name of medication to be administered, the dosage and the time of day or intervals at which the drug is to be administered. If generic drug is sent, both drug names are necessary.

| 1. Prescription or Non-pre. | Name of Drug | Generic Name | Dosage Time/Intervals |
|---|---|---|---|
| P ☐ NP ☐ | _____ | _____ | _____ |

Reason medication is needed: _____

Possible adverse reactions that, if they occur, should be reported to the parent and/or physician: _____

_____

Date administration begins _____ / _____ / _____ Date administration ends _____ / _____ / _____

Special instructions for administration or storage of medication. Please note, refrigeration is not available.

_____

_____

| 1. Prescription or Non-pre. | Name of Drug | Generic Name | Dosage Time/Intervals |
|---|---|---|---|
| P ☐ NP ☐ | _____ | _____ | _____ |

Reason medication is needed: _____

Possible adverse reactions that, if they occur, should be reported to the parent and/or physician: _____

_____

Date administration begins _____ / _____ / _____ Date administration ends _____ / _____ / _____

Special instructions for administration or storage of medication. Please note, refrigeration is not available.

_____

_____

## Both physician and parent signatures are required to administer medication

Physician's Name _____ Phone # I.C.E. _____

Physicians Signature _____ Date _____ / _____ / _____

Physicians Address _____

Parent/Guardian Signature _____ Date _____ / _____ / _____

Parent/Guardian Phone # I.C.E. _____

| Medication | Dosage | Administered by | Date | Time |
| --- | --- | --- | --- | --- |