

Poland Summer Recreation Camp

Medication Administration Form

This form must be filled out by a parent/guardian when it becomes necessary for a program participant to receive medication during program hours. All medication must be provided to staff in its original container, and must be labeled by a pharmacist or physician. Please understand that some medication due to potential risk and side effect, may require us to seek out additional information/resources.

Participant Name: _____ DOB: _____ Age: _____

Parent Name: _____ Daytime Phone#: _____

Parent Name: _____ Daytime Phone#: _____

Medication being administered: _____

Duration of administration: _____ to _____ Days to administer: M T W Th F
start date end date

Time of administer: _____ am pm _____ am pm

This medication can be *self-administered* by program participant

This medication should be *administered by staff* to program participant

How to administer: _____

Reason for medication: _____

Side effects: _____

Other necessary information: _____

I give my permission for Poland Summer Recreation Camp Director or Assistant Director to *administer* medication to my dependent as state above.

Signature of Parent/Guardian: _____ Date: _____

-OR-

I give my permission for Poland Summer Recreation Camp Director or Assistant Director to supervise the *self-administration* of medication by my dependent as stated above.

Signature of Parent/Guardian: _____ Date: _____