CampACC

Consent for Medication Administration

Camp Session:_____

Program Director: _____

Camper's Name: _____

Age:_____

Weight: _____

Allergies:_____

Please bring this form with the medication at the beginning of camp. Please do not mail this form in before camp. Bring medication(s) in the original, labeled container.

Name of medication				
Reason for medication				
Amount to be given				
How to be given				
Time(s) of day to be given ***Please check all times that apply*	Breakfast	Lunch	Dinner	Bedtime
	Other (*please specify*)			
Discontinuation date				

Name of medication				
Reason for medication				
Amount to be given				
How to be given				
Time(s) of day to be given ***Please check all times that apply*	Breakfast	Lunch	Dinner	Bedtime
	Other (*please specify*)			
Discontinuation date				

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Reason for medication				
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Time(s) of day to be given ***Please check all times that apply*	Breakfast	Lunch	Dinner	Bedtime
	Other (*please specify*)			
Discontinuation date				

Your signature verifies that your child may receive the above medication(s) as indicated.

_____ _____

Parent's/Guardian's signature and consent *Date*

THIS IS TO BE FILLED OUT AT THE END OF THE SESSION

Medications picked up by: _____*Date:*

Medications released by: _____*Date:*