ADMINISTRATION OF MEDICATION FORM:

Child's Name: _____

Address: _____

Name of Medication: _____

Purpose of Medication: _____

Physician's requirement for dosage and method of administration:

_____

_____

_____

What to do in case of side effects: _____

_____

Termination Date for administering the medication: _____

_____ _____

Physician's Signature: **Date:**

_____ _____

Parent's Signature: **Date:**

Approved By:

_____ _____

Camp Director/Staff Member **Date:**