



K-E CAMPS

AUTHORIZATION TO ADMINISTER MEDICATION

To Be Completed by Parent/Guardian *only* if camper needs medication during the camp day.

Camper Name _____ Birth Date _____ Gender _____

Parent 1 Name _____ Cell Phone _____ Work Phone _____

Parent 2 Name _____ Cell Phone _____ Work Phone _____

Physician _____ Phone _____

I REQUEST THAT MY CHILD BE ASSISTED IN TAKING THE MEDICINE(S) DESCRIBED BELOW AT CAMP BY CAMP STAFF. (If more than one medication is required, please complete a separate authorization form for each.)

Name of Medicine: _____

Reason for medication: _____

Form: Tablet Liquid Chewable Drops Other (specify) _____

Dose: _____

If medicine is to be given DAILY, at what time? _____

If medicine is to be given WHEN NEEDED, describe indications: _____

Possible Side Effects/Adverse Reactions: _____

Other Comments: _____

Parent Signature _____ **Date** _____