Authorization for the
Administration of Medicine
West Haven Parks and Recreation

Physician's Order Date _______________

Name of Child _________________________________ Date of Birth ___/___/____

Address_________________________ City ______________ State _______ Zip _______

Condition for which drug is being administered: _________________________________

Name of Drug: __________________ Amount of drug: __________ Administration time _______

Length of time during which medication shall be administered: from _________ to _________

Relevant side effects to be observed, if any: ____

____

____

Other suggestions: ____

Physician's Signature _____________________________________ M.D.

Address ______________________________ Phone __________________

Authorization by Parent or Guardian
Allowing the administration of
Medication by Day Camp Personnel

To: ____________________________________ Date______________________
Name of Camp

I hereby request that camp personnel give my child ___________________________ the Medication ordered by his/her physician.
Name of child

______________________________________ __________________________________
Name of Parent/Guardian Signature

Address: ______________________________ Phone: ___________________________