AUTHORIZATION TO ADMINISTER MEDICATION

In order for children who need to take over the counter or prescription medications during summer camp or Before/After School care, this form needs to be completed in its entirety by a parent/guardian and physician before any medication can be given by staff members, including over the counter medications. If the form is incomplete or not on file, the parent will need to return to the Kidz Korner to administer the medication regardless of the age of the child.

Parents, please complete this section

The parent/guardian of _____ ask that the camp staff give the
(child's first and last name)
following medication _____ at _____
(Name of medication, one medication per sheet) (Time)
to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

Prescription medications must come in the original container labeled with: child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped and licensed health care provider's name. Pharmacy name and phone number must also be included on the label. Ask your pharmacist for a separate medicine bottle to keep at the Kidz Korner.
Over the counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packed in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the Kidz Korner staff.

_____ _____ _____
Parent/Guardian's Printed Name Parent/Guardian's Signature Date

_____ _____ _____
Home Phone Work Phone Cell Phone

Health Care Provider Authorization to Administer Medication at Day Camp

Child's Name _____ Date of Birth _____

Medication _____ Dosage _____

Route _____

To be given at the following time(s) (be specific, we cannot use "as needed") _____
_____

Special Instructions _____

Purpose of medication _____

Side effects that need to be reported _____

Physician/Health Care Professional Signature: _____

It is understood that the medicine is administered at the request of and as an accommodation to the undersigned parent (s) or guardian (s). In consideration of the acceptance of the request to perform the service by personnel employed by Clear Creek Metropolitan Recreation District, the undersigned hereby agrees to release the Clear Creek Metropolitan Recreation District and its officers, agents, servants, and employed from legal claims which they now have or may hereafter have arising out of the administration of (or failure to administer) the medication to the participant.

Parent/Guardian Signature:_____ Date:_____

RETURN