



## French Summer Camp Authorization to Administer Medication in Program

Camper Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### Part I

Dear Parent,

When considered medically necessary, campers may receive medications and treatments as ordered by a licensed healthcare provider, during the camp day. Should the student display any adverse reactions, the parent will be contacted immediately, emergency care will be provided as needed and the medication/treatment discontinued. Please complete the following information.

- NO MEDICATION OR TREATMENT may be given by the program nurse or designee until this form is completed and properly labeled medication is received. THIS INCLUDES OVER THE COUNTER MEDICATIONS SUCH AS TYLENOL, MOTRIN, AND COUGH DROPS.
- A parent signature must be on this form.
- All medications must be stored in their original containers with an appropriate pharmacy label on each bottle. All labels will include the student’s name, dose, frequency, route, time of administration of the medication.

### Part II

Medication Treatment #1:

Name of Drug/Treatment \_\_\_\_\_

Dosage \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_ (include times and duration)

Medication form pill/capsule inhaler ear drops eye drops liquid injectable

Known adverse reactions/side effects \_\_\_\_\_

Prescribed treatment for side effects, if other than as outlined above \_\_\_\_\_

Medication Treatment #2:

Name of Drug/Treatment \_\_\_\_\_

Dosage \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_ (include times and duration)

Medication form pill/capsule inhaler ear drops eye drops liquid injectable

Known adverse reactions/side effects \_\_\_\_\_

Prescribed treatment for side effects, if other than as outlined above \_\_\_\_\_

### Part III

Parent Permission:

I hereby give permission for my child to receive the above medications/treatments during camp hours, 9am-4pm. I understand that medications may be administered by the program registered nurse or designee. This designee may be a non-medical person. If a treatment requires a medical or nursing assessment prior to administration, and a licensed medical person is not available, the medication and/or treatment will not be given. This medication and/or treatment is considered a medical necessity and ordered by a licensed healthcare provider. I hereby release the FAUS District, its agents and employees from any and all liability that may result from my child receiving this medication and/or treatment.

\_\_\_\_\_  
Parent/Guardian Signature Date Telephone #

\_\_\_\_\_  
Parent/Guardian Print Office Use Only:  
Secured in locked cabinet:  Yes  No