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 mediations must be stored in their original containers with an appropriate pharmacy label on each bottle. All labels will include the student's name, does, 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