Franklin Country Day Camp
Authorization For Medication

The following section is to be completed by the Parent or Guardian

Child's name: ______________________________ ____________ ____________

Last First Sex Date of Birth

______________________________ (____)____________

Physician's Name Address Telephone

I request that my child be assisted in taking the medicine(s) described below at camp by authorized persons as authorized by me and my physician.

________ ______________________ (____)__________ (____)__________

Date Parent/Guardian Signature Home Phone Emergency Phone

The following section is to be completed by the PHYSICIAN

Diagnosis for which medication is given:______________________________

Name of Medication:______________________________

Form:______________________________

Dose:______________________________

If medication is to be given at camp, at what time?______________________________

If medication is to be given "WHEN NEEDED" describe indications:______________________________

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How soon can it be repeated?______________________________

List significant side effects:______________________________

Length of time this treatment is recommended:______________________________

Other Information: ______________________________

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____________ ______________________________

Date **PHYSICIAN'S SIGNATURE**