

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:_____	
How soon can it be repeated?_____	
List significant side effects:_____	
Length of time this treatment is recommended:_____	
Other Information: _____	

_____ Date	_____ PHYSICIAN'S SIGNATURE