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**