

ALLEN PARKS & RECREATION - CAMP S.T.A.R.

MEDICATION CONSENT FORM

OPTIONAL FORM

VALID FOR LENGTH OF PRESCRIPTION / INSTRUCTIONS BY PHYSICIAN, i.e. antibiotic 10 days, unless otherwise stated by Physician.

Name: _____ Date: _____
Last Name, First Name

Medication Name: _____ Dosage: _____

Time (AM/PM) and Date to be Administered: _____

Reason for Medicine: _____

Is condition contagious? *(Please circle one)* YES NO

Child's Physician: _____ Physician Phone #: _____

Parent Best Contact #: _____ Second Phone #: _____

Allen Parks and Recreation Department staff has my permission to administer this medication to my child according to instructions above.

 Parent/Guardian - Print Name

 Parent/Guardian - Signature

NO medication will be administered without a signed form. **ALL** medication must be in its original medicine container, enclosed in a zip lock bag with child's first and last name printed on outside of bag. Medicine needs to be delivered to the Camp Lead or Joe Farmer Recreation Center staff member.

Date: _____ Time: _____ Dosage: _____

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