

-----Authorization for Medication-----

Child's Name _____ Birth date _____

Age _____ Allergies _____

Name of 1st medication: _____

Dose and Time to be given: _____

Name of 2nd medication: _____

Dose and Time to be given: _____

THIRD MEDICATION (If there is a third medication, please check the box, and write the name and dosage on the back of this page)

If prescribed on an "as needed" basis, please provide detail:

Side effects if any:

Please indicate if this medication is **PRESCRIPTION MEDICATION**: Yes No

If yes, is the medication in the original container with the prescription label:
 Yes No (if NO is checked, physician authorization form is required.)

I am the legal guardian of the child listed above. I hereby give my permission for the administration of the medication(s) listed above in the dosage and directions I have provided to be given to my child by the staff of EPCBC Kids Camp. I have provided accurate information and have submitted Physician Authorization if necessary. I give this permission for today's date, July 28, 2022 through July 31, 2022.

Signature: _____ Date: _____

Printed Name: _____ Phone Number: _____

For EPCBC check-out use	
Medications Returned to Guardian:	YES NO If no, reason: _____
Guardian Signature: _____	Staff Initials: _____