----------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 27, 2023 through July 30, 2023.

Signature: _____ Date: _____

Printed Name: _____ Phone Number: _____

For EPCBC check-out use

Medications Returned to Guardian: YES NO If no, reason: _____

Guardian Signature: _____ Staff Initials: _____