Administration of Medication Authorization

The Carousel Dance Centre Inc. – SummerDance 2010

I, _____ authorize the administration of (name of medication) _____

_____ to (child's name) _____

for (reason) _____ by the Camp Director or a staff member designated by the Camp Director.

Date medicine started: _______________ (Month \ Day \ Year) Date medicine started at Camp: _______________ (Month \ Day \ Year)

End Date: _____ Dosage: _____

Times of Administration:

1. _____ 2. _____

3. _____ 4. _____

Is *refrigeration* required? Yes ____ No ____ Special Instructions: _____

_____

(e.g. "Must be taken with food.")

Side effects: _____

_____

Stop medication if the following reaction(s) observed: _____

_____

Has this medication been prescribed by a physician: Yes ____ No ____

If yes, prescribing physician's name: _____ Phone Number: _____

_____ _____

Parent/Guardian's Signature Date

PLEASE FILL OUT FORM COMPLETELY

Prior to administering, medication must be authorized by Director, Supervisor or designate.