

AUTHORIZATION TO ADMINISTER MEDICATION

(To be completed by parent/guardian)

Name of Child: _____ Age: _____

Food/Drug Allergies: _____

Diagnosis (at parents' discretion): _____

Emergency Telephone: _____

Parent/Guardian Name: _____

Home Telephone: _____

Cell Phone: _____

Name of Licensed Prescriber: _____

Business Telephone: _____

Section A: Authorization to Administer by Camp Personnel

I hereby authorize health care supervisors from the Maria Mitchell Association to administer the medications below as directed to my child.

Medication	Dosage	Dosage schedule	Condition Requiring Meds	Side effects	Special storage requirements	Special Instructions

Additional Comments:

Parent/Guardian Signature: _____ Date: _____

Section B: Authorization to Self-Medicare

Please complete if your child will be bringing an Epipen, inhaler, or insulin and you wish for him/her to administer it independently.

My child has a physical condition which requires him/her to routinely receive medication as quickly as possible in order to avoid a medical crisis or to manage his/her medical condition. In the interest of his/her personal well being, I hereby grant my child the authority to carry the medication or medications listed below and to self-administer it as directed by the prescribing physician when needed.

Medication	Dosage	Dosage schedule	Condition Requiring Meds	Side effects	Special storage requirements	Special Instructions

Additional Comments:

Parent/Guardian Signature: _____ Date: _____