



COMMUNITY DAY CAMP

Medication Release Form

This form MUST be turned in with all youth participant Registration Forms

Name of Day Camp: _____ Camp Dates: _____

Child's Name _____

I request that my child _____ of troop # _____
(name)

be given _____ by the camp health supervisor.
(medication)

Medication	Time	Dose	Repeated at what interval

Physician prescribing medication _____

Phone # of physician (_____) _____

In light of the correlation between Reye's Syndrome and aspirin indigestion, no aspirin or aspirin products may be administered at camp. If it is medically necessary for your child to receive aspirin, a physician's authorization must accompany the medication.

Please list any allergies:

My child is **NOT** taking any medication

PLEASE NOTE – WE CANNOT KEEP OVER THE COUNTER MEDICATION AT CAMP TO DISPENSE. IF YOU FEEL YOUR CHILD WILL NEED MEDICATION OF THIS NATURE, PLEASE PROVIDE THE TYPE OF MEDICATION IN ITS ORIGINAL BOTTLE IN A BAG WITH THE CAMPER'S NAME ON IT ALONG WITH THIS FORM GIVING AUTHORIZAITION TO ADMINISTER.

Signature of Parent or legal Guardian _____ Date _____

Phone _____