

Authorization (To be completed by parent/guardian) EACH MEDICATION REQUIRES SEPARATE FORM

CHILD'S NAME	AGE
MEDICATION	PRESCRIPTION #
REASON FOR MEDICATION	EXPIRATION
DOSEAGE (must match label's dosage)	
SCHEDULED TIME	
START DATE	STOP DATE
IS THE START DATE THE FIRST TIME THIS CHILD HAS TAKEN THIS MEDICATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	

ROUTE:

- MOUTH
- EAR R / L
- EYE R / L
- SKIN
- NOSE R / L
- OTHER _____

REFRIGERATION NEEDED?

- YES
- NO

I authorize Boonton Parks and Recreation Summer Camp staff to administer the following prescription medication or over-the-counter medication to the child named here. In addition, I will provide a list of potential side effects, obtained at the pharmacy, for prescription medications.

- Physician Ordered**
 (required for all prescription medications, or if instructions differ from label)

Physician Name: _____

 PARENT/GUARDIAN SIGNATURE

 DATE

FOLD HERE

LOG (for staff use only)

Complete each time medication is given to this child.

DATE	TIME	MEDICATION	DOSAGE	CONTROLLED SUBSTANCE? PILL COUNT RECEIVED	NOTES: (Medication was self-administered, observed side effects or reactions, errors, etc.)	Staff Signature

THIS AUTHORIZATION FORM IS VALID FOR ONE YEAR. THIS FORM IS TO BE USED WHEN NO SPECIFIC STATE FORM IS REQUIRED.