Camp Adventure & Sunny Day Camp
MEDICATION AUTHORIZATION FORM

Child's Name: _____ **DOB:** _____

The above named child requires that the following medications be taken:

Medication: _____

Dosage: _____ **Time:** _____

Reason for medication: _____

Possible Side Effects: _____

☐ **Child may self-carry/administer above named mediation**

Medication: _____

Dosage: _____ **Time:** _____

Reason for medication: _____

Possible Side Effects: _____

☐ **Child may self-carry/administer above named mediation**

Physician's Signature: _____ **Date:** _____

Physician's Address: _____

Physician's Phone Number: _____

I, being the parent/guardian of the above child, give the Town of Bethlehem Parks & Recreation Department permission to discuss with the physician this medication order.

Parent/Guardian Signature: _____ **Date:** _____