ALLEN PARKS & RECREATION - CAMP S.T.A.R.

MEDICATION CONSENT FORM

OPTIONAL FORM

VALID FOR LENGTH OF PRESCRIPTION / INSTRUCTIONS BY PHYSICIAN, i.e. antibiotic 10 days, unless otherwise stated by Physician.

Name: ____________________ Date: ____________
Last Name, First Name

Medication Name: ____________________ Dosage: ____________

Time (AM/PM) and Date to be Administered: ____________________

Reason for Medicine: ____________________

Is condition contagious? *(Please circle one)* YES NO

Child's Physician: ____________________ Physician Phone #: ____________

Parent Best Contact #: ____________ Second Phone #: ____________

Allen Parks and Recreation Department staff has my permission to administer this medication to my child according to instructions above.

____________________ ____________________
Parent/Guardian - Print Name *Parent/Guardian - Signature*

NO medication will be administered without a signed form. ALL medication must be in its original medicine container, enclosed in a zip lock bag with child's first and last name printed on outside of bag. Medicine needs to be delivered to the Camp Lead or Joe Farmer Recreation Center staff member.

Date: ______ Time: ______ Dosage: ______ Date: ______ Time: ______ Dosage: ______
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CITY OF ALLEN
PARKS & RECREATION

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