Authorization for the
Administration of Medicine
West Haven Parks and Recreation

Physician's Order Date _____

Name of Child _____ Date of Birth ___/___/____

Address_____ City _____ State _____ Zip _____

Condition for which drug is being administered: _____

Name of Drug: _____ Amount of drug: _____ Administration time _____

Length of time during which medication shall be administered: from _____ to _____

Relevant side effects to be observed, if any: _____

_____

_____

Other suggestions: _____

Physician's Signature _____ M.D.

Address _____ Phone _____

Authorization by Parent or Guardian
Allowing the administration of
Medication by Day Camp Personnel

To: _____ Date_____
Name of Camp

I hereby request that camp personnel give my child _____ the
Medication ordered by his/her physician. Name of child

_____ _____
Name of Parent/Guardian Signature

Address: _____ Phone: _____