NAME OF CAMPER: _____

MEDICATION ADMINISTRATION AUTHORIZATION FORM

Supplemental Emergency Medical Plan Document

This form is due by the registration deadline of the first session of Campus Recreation RECkids Camp attendance. Please Note: UD will receive, approve, and administer medication to children when the medication is needed for chronic or life-threatening conditions (such as asthma treatments or emergency allergy medication). Other medications, such as antibiotics – which can be administered outside of camp hours – should be cared for by parents/guardians rather than the camp staff/event planners. *Medicine MUST be in its original container. **Complete an additional form for each medication.

MEDICATION INFORMATION

CHILD'S LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH (MM/DD/YYYY) _____

MEDICATION NAME: _____

CIRCUMSTANCE IN WHICH MEDICATION WOULD NEED TO BE ADMINISTERED: _____

_____

DOSAGE AMOUNT: _____

WHAT SYMPTOMS WOULD REQUIRE ADMINISTRATION OF THIS MEDICATION? _____

_____

_____

SPECIAL INSTRUCTIONS FOR ADMINISTERING "AS NEEDED" MEDICATION: _____

_____

The information provided is true and correct as far as I know:

PRINT NAME OF PARENT/LEGAL GUARDIAN _____ SIGNATURE OF PARENT/LEGAL GUARDIAN _____ DATE _____

PRINT NAME OF DOCTOR _____ SIGNATURE OF DOCTOR _____ DATE _____

MEDICATION ADMINISTRATION AUTHORIZATION

Dear Parents/Guardians, you have identified that your child may require specific prescribed medication in the event of an emergency medical situation. By signing this form, below, you authorize UD to administer the medication as indicated above.

PRINT NAME OF PARENT/LEGAL GUARDIAN _____ SIGNATURE OF PARENT/LEGAL GUARDIAN _____ DATE _____

FOR CAMPUS RECREATION RECKIDS CAMP STAFF | ADMINISTRATION DOCUMENTATION:

Phone Contact Time & Date	Date Given	Time Given	Dosage	Staff Printed Name and Signature