DOVERCOURT

**for camp office use only

Storage Location
☐ campers backpack
☐ camp office

Program (CAMP) Name:
W1 (July 2-4): _____
W2 (July 7-9): _____
W3 (July 14-18): _____
W4 (July 21-25): _____
W5 (July 28- Aug 1): _____
W6 (Aug 5-8): _____
W7 (Aug 11-12): _____
W8 (Aug 18-22): _____
W9 (Aug 25-29): _____

Administration of Medication Authorization

NOTE: Please type or print neatly and submit the original, signed copy to CAMP OFFICE. In the case of ongoing serious medical conditions (such as but not limited to severe, life-threatening allergies, diabetes, epilepsy, heart condition, asthma), this authorization will terminate on June 30 of each year. Please notify us if the prescription changes or expired.

ADVISEMENT OF ADMINISATION OF MEDICATION

Client Name: _____ Parents /Guardians: _____

Address: _____ Phone (Home): _____

Email: _____ Parent Cell Phone: _____

Physician's Name: _____ Physician's Phone: _____

MEDICATION INFORMATION

In my opinion, it is necessary that the following medication be administered during program hours:

- **Allergy & Name of Medication:** _____
- **Storage Cautions, if any:** _____
- **Dosage of Medication:** _____
- **Time of Administration:** _____
- **Special instructions for Administration:** _____
- **Duration of Medication Regime:** _____
- **Caution of Notable Side Effects:** _____

PARENT / GUARDIAN AUTHORIZATION

The responsibility for administration of medication involves certain elements of risk. Unexpected consequences including, but not limited to, illness, adverse reactions or other complications may occur as a result of the administration (or non-administration) of any medication. These physical reactions result from the medication and can occur without fault on either the part of the client or Dovercourt Recreation Association (DRA) or its employees or agents. By requesting and consenting to the administration of medication by DRA the client, you are assuming the risk of an unexpected reaction occurring. It is understood that the chances of such a reaction occurring may be reduced by carefully following the instructions provided by the physician and / or pharmacy at all times. If you consent to the administration of medication to the client by Dovercourt staff, you must understand that you and not DRA will bear sole responsibility for any reaction that might occur.

I have read the above and I understand that in requesting and consenting to the administration of medication by Dovercourt Recreation Association, I am assuming the risks associated with doing so.

Name of Medication: _____ **Prescription number:** _____

The parent(s)/guardian(s) of hereby consent that the above medication, using the procedures as outlined by the physician, be administrated to the client by DRA, its employees or agents. It is acknowledged that the employees or agents of DRA are not medically trained to administer medication.

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