Authorization for Medication

CHILD'S NAME: ____ AGE:__________

ADDRESS: ____

____

HOME PHONE: ____________________ CELL PHONE: ______________________

The above named child must take _________________________ during camp hours.
(medication)
_____________________________ should be administered at ___________________.
(dosage) (time)

Effect of medication upon student: ____

____

____

Effects of medication that indicate further contact with physician is needed:

____

____

____

Date: ______________________ ______________________________
(Physician's Signature)

____
(Physician's Name)

I, the parent/guardian of the above named child, request that Great Lakes Athletic Club summer camp staff administer this medication following the physician's directions. I assume full responsibility and hereby release Great Lakes Athletic Club, its employees, volunteers, shareholders, directors, officers, representatives and agents from all liability in connection with this request.

____________________________ ______________________________
(Date) (Parent's Signature)

NOTE: Medication sent to camp must be labeled with child's name, name of medication and dosage.