

PARENTAL AUTHORIZATION TO ADMINISTER MEDICINES AT CAMP

Start Date

Day	Month	Year
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Stop Date

Day	Month	Year
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Parents please fill in the following information, if known

Name of camp unit:

Group #:

Name of camp bus:

Child's Name

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Name of medication, dosage & reason for medication. Specify if you want this medication returned home daily.

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Signature of parent or guardian

Telephone

Date

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PARENTS: Please cut and use this form when sending medicines to camp. Photocopy to create additional copies.

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