



AUTHORIZATION FOR CHILD-ADMINISTERED MEDICATIONS

THIS FORM MUST BE FILLED OUT BY A PARENT AND THE AUTHORIZED PRESCRIBER IF A CHILD NEEDS TO TAKE MEDICATION DURING CAMP HOURS.

The Children's Museum's staff is not authorized to administer medications. Campers may self-administer medications with documented parental and authorized prescriber permission. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber or dentist's name, and date of original prescription. Over the counter medication must be in the original container and labeled with the child's name.

AUTHORIZED PRESCRIBER OR DENTIST'S ORDER

Date: / /

Name of Child: _____ Date of Birth / /
Street Address _____ City/Town _____ State _____

Condition for which drug is being administered during camp hours:

DRUG: Name of drug, dose, and method of administration:

Times of Administration: _____, _____, _____, _____

Relevant side effects to be observed, if any:

If there are side effects, plan for management:

Is this a controlled drug? Yes _____ No _____

Allergies, reaction to, or negative interaction with food or drugs? Yes _____ No _____

If yes, list: _____

The authorized Prescriber's or Dentist's name: _____ Phone _____

Street Address _____ City/Town _____ State _____

Authorized Prescriber or Dentist's Signature: _____

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION

Date: / /

I understand that The Children's Museum's staff is not authorized to administer medications. I hereby request that the above medication, ordered by the authorized prescriber/dentist for my child, _____, be self-administered by said child.

I understand and agree to the terms indicated in the shaded box above. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order.

Name of Parent/Guardian _____ Relationship to child _____

Signature of Parent/Guardian _____

Street Address _____

City/Town _____ State _____ Zip _____ Phone _____