Request for School Personnel to Administer Medication

Please complete all information on this form and return it to the Camp Crusader office.

Child's Name: _____

Medication to be administered:
_____

Dosage: _____ Time of Day to be administered: _____

Reason for medication: _____

Anticipated number of days the medication will need to be administered during Camp Crusader hours: _____

Possible side effects: _____
_____

(Signed physician statement must accompany this request form.)

My signature authorizes the Camp Crusader Director, or designee to administer the medication, as stated on this form, to my child, _____, and that any side effects from the medication are not the school's responsibility.

_____ _____

Parent/Guardian Signature Date