Camper Medication Form

Participant Name _____

❑ **This person will need to take medication during program hours**
This person routinely takes the following medications including over-the-counter or non-prescription medications:

Name of Medication	Dosage	List Time(s) to be taken	Name of Doctor
How? (i.e. with water, after meal, on empty stomach, etc.)			
Reason for taking			

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How? (i.e. with water, after meal, on empty stomach, etc.)			
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How? (i.e. with water, after meal, on empty stomach, etc.)			
Reason for taking			

I want the program to: (check all that apply)
❑ Store camper's medication ❑ Remind and watch camper take medication ❑ In emergency, know about camper's medications

Please talk with the camp director about medication needs and schedules. Package medication in pill reminder boxes or envelopes clearly marked with participant's name, day and time medication is to be taken. Call regarding liquid medication or medication that must be refrigerated.

I hereby request Metro Parks Tacoma (MPT) personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless MPT and any of their staff members, or director from lawsuits, claims, expenses, demands, or actions, etc. against them for helping this student use medication.

_____ _____
Date Signature of Parent or Legal Guardian