Discovery Day Camp
MEDICATION AUTHORIZATION FORM

Child's Name:_____ **DOB:**_____

The above named child requires that the following medications be taken:

Medication:_____

Dosage:_____ **Time:**_____

Reason for medication:_____

Possible Side Effects: _____

☐ **Child may self-carry/administer above named medication**

Medication:_____

Dosage:_____ **Time:**_____

Reason for medication:_____

Possible Side Effects: _____

☐ **Child may self-carry/administer above named medication**

Physician's Signature:_____ **Date:**_____

Physician's Address:_____

Physician's Phone Number:_____

I, being the parent/guardian of the above child, give the Town of Bethlehem Parks & Recreation Department permission to discuss with the physician this medication order.

Parent/Guardian Signature:_____ **Date:**_____