Week:	**Group:**
Staff: *to be completed by staff	

MEDICAL ADMINISTRATION FORM

Administration Information	
Participant name:	Dates of camp:

Name of medication	Time medication is to be administered	Amount/dosage to be administered	Storage requirements

Medication Name **to be completed by Camp Staff*

Monday	Time				
	Dosage				
	Admin. By (Name & Signature)				
	Witness By (Name & Signature)				
Tuesday	Time				
	Dosage				
	Admin. By (Name & Signature)				
	Witness By (Name & Signature)				
Wednesday	Time				
	Dosage				
	Admin. By (Name & Signature)				
	Witness By (Name & Signature)				
Thursday	Time				
	Dosage				
	Admin. By (Name & Signature)				
	Witness By (Name & Signature)				
Friday	Time				
	Dosage				
	Admin. By (Name & Signature)				
	Witness By (Name & Signature)				

I, the undersigned, hereby:

- Certify that the information above is accurate and complete.
- Authorize CDRC staff to administer the above-mentioned medication(s) to my child/dependent applicable to the timeframes and dos- ages identified.

_____ _____

Parent/Guardian Signature *Date*