Authorization for Administration of Medication

Medicine Administration

Program: _____ Program Site: _____

Participant Name: _____

The dates the child will be attending: _____

I, _____, authorize North Perth Parks &
(parent/guardian name)

Recreation staff to observe the self-administration of _____
(name of medication)

_____

to _____. Program staff should be aware of the following
(child's name)

instructions: _____

_____

_____.

This authorization is effective for the following dates: _____.

Side effects: Stop medication if the following reaction(s) is/are observed: _____

_____

_____.

Storage required for medication: _____

All medications must be stored with the staff in a secure location. Your child may only carry epi-pens, inhalers, and diabetic supplies if he/she wears them in a waist pouch. If your child does not have a waist pouch the camp staff must carry their supplies to ensure safety for all participants.

Parent/Guardian Signature: _____

Date: _____

Municipality of North Perth Parks & Recreation Department
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