Parent/Guardian Authorization for the Administration of Non-Prescription Topical Medications by Camp Personnel

****** PLEASE PRINT CLEARLY ON THIS FORM*****

I authorize my child __________________________ to have topical medication applied. Yes____ No____

IF YES PLEASE CONTINUE BELOW:

I hereby request that the following non-prescription topical medications be administered to my child by a camp staff member of the **Sterling Park Day Camp**.

I understand that I must supply the camp with the <u>non-prescription topical medication in the original container</u> labeled with the child's name, name of the medication, and the directions of the medication administration.

This authorization is limited to the following topical medications: 1. DEET bug Repellant 2. Creams / Lotions / Sunscreen 3. Lip medications (Chapstick)

Date of Birth: _________________

Address: ____

Name of Medication: ____

Schedule of Administration: ____

Reason medication is being administered: ____

Medication shall be administered from: _______________________ to: _______________________

Name of Parent/Guardian ____ Date: ________________

I have administered at least one dose of the above medication to my child without adverse side effects.

Signature: ________________________________ Relationship to child: ______________________

Address: ________________________________ Telephone: ________________________________

Staff to complete: Parent authorization form and medication received by: ______________________ (Signature of staff) Medication Started: ________________________________ (date and time) Medication Ended: ________________________________ (date and time) Parent permission and medication administration record shall become part of the child's health record when the medication has ended.