



# MONMOUTH COUNTY PARK SYSTEM MEDICATION AUTHORIZATION FORM

**Participant's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

We highly recommend and encourage that medications be administered prior to or after the camp session, however; we recognize that there may be occasions where medicine may need to be administered with supervision during the camp day. Any medication other than rescue medications (benadryl with epi-pen, epi-pen, or asthma inhaler) will only be administered with supervision at a location where a camp nurse is present such as Dorbrook Recreation Area.

1. All prescription and non-prescription medication (over the counter) require a physician's authorization and shall be labeled and stored in the original prescription container.
2. All medication is maintained under staff supervision and the staff supervises the administration of this medication. The only exception to this is Asthma inhalers, which may be carried on the person, but must be clearly labeled with doctor's protocol.
3. Parents/Guardians must sign the medication authorization form below.

### Parental Request

I, the parent/guardian of \_\_\_\_\_ request that the rescue/prescription medication prescribed by my child's physician be administered to my child by a trained staff member (for rescue medications only such as epi-pens, benadryl with epi-pens or asthma inhalers) or the camp nurse (for other prescribed medications for campers at Dorbrook Recreation Area). The medication will be brought to camp in its original container appropriately labeled by my pharmacy.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Home Phone Number

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Cellular Number

### Physician's Authorization

In order to protect the health of \_\_\_\_\_, it is necessary for him/her to have the following medication during camp hours.

MEDICATION: \_\_\_\_\_

DOSAGE: \_\_\_\_\_

TIME to be administered: \_\_\_\_\_

Purpose of medication: \_\_\_\_\_

List any possible side effects: \_\_\_\_\_

I authorize the camp nurse or qualified staff member to administer the above medication.

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_

Print Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_