



PARKS & RECREATION DEPARTMENT

**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT CAMP**

Camper's Name

Birth date

Camp Location

---

**THIS PORTION TO BE COMPLETED AND SIGNED BY THE PHYSICIAN  
IF IT IS NECESSARY TO DISPENSE MEDICATION DURING CAMP HOURS**

Name of Medication

Dosage

Method of Admin.

Time of Day to be taken

*Reason for medication to be given during camp hours:*

*Possible side effects of medication:*

*Emergency procedure in case of serious side effects:*

---

**\*\*\*MEDICATION MUST BE SUPPLIED IN THE ORIGINAL CONTAINER\*\*\***

---

I request and authorize that the above named child be administered the above identified medication in accordance with the instructions indicated above from \_\_\_\_\_ to \_\_\_\_\_. **There exists a valid health reason which makes administration of medication advisable during camp hours** or during such time that the camper is under the supervision of the Thurston County Parks and Recreation Department. Such medication may be administered by medically untrained personnel.

Date of Signature

Physician's/Dentist's Signature (Physician's Assistants orders to be countersigned by the supervising physician.)

Phone

Physician's Name (Please print or type)

Address

City

State

Zip

---

**THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN**

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the Thurston County Parks & Recreation Department (TCPRD) to administer the above identified student in accordance with the prescription or doctors instructions from \_\_\_\_\_ to \_\_\_\_\_ not to exceed one calendar year. **Medications will be supplied to the camp in the original container.**

Date

Signature

Daytime Phone