

# PERMISSION TO ADMINISTER MEDICATION

I GIVE THE TOWN OF AURORA DEPARTMENT OF PARKS & RECREATION  
SUMMER DAY CAMP PROGRAM PERMISSION TO ADMINISTER THE FOLLOWING  
MEDICATION TO MY CHILD:

CHILD'S NAME \_\_\_\_\_

PRESCRIBING DOCTOR \_\_\_\_\_

NAME OF MEDICATION \_\_\_\_\_

DOSAGE \_\_\_\_\_

FREQUENCY \_\_\_\_\_

EFFECTIVE DATE \_\_\_\_\_

DURATION OF ORDER \_\_\_\_\_

REASON FOR MEDICATION \_\_\_\_\_

ADDITIONAL INFORMATION \_\_\_\_\_

\_\_\_\_\_

PARENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

DOCTOR'S SIGNATURE \_\_\_\_\_

(OR ATTACHED PRESCRIPTION)

---

## FOR OFFICE TO COMPLETE

NURSE'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

MD \_\_\_\_\_

ALLERGIES \_\_\_\_\_