



**York Parks & Recreation Department**  
*Medication Administration Form*

The parent/guardian of \_\_\_\_\_ ask that camp staff give the following  
(Campers Name)  
medication \_\_\_\_\_ at \_\_\_\_\_ to  
(Name of Medication & Dosage) (Time(s))  
my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The York Parks & Recreation Department agrees to administer medication prescribed by a licensed health care provider. It is the parent/guardian's responsibility to provide the medication. The parent agrees to pick up unused or expired medication within one week of notification by staff.

**Prescription Medications:** Must come in a container labeled with; child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care providers name. The pharmacy's name and phone number must also be included on the label.

**Over the Counter Medications:** Must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the camp nurse or camp staff delegated to administer medication.

Parent/Legal Guardian's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian's Signature: \_\_\_\_\_ Phone #: \_\_\_\_\_

---

**HEALTH CARE PROVIDER AUTHORIZATION TO ADMINISTER MEDICATION AT CAMP**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

To be given at (time(s)): \_\_\_\_\_ Special Instructions: \_\_\_\_\_

Purpose of Medication: \_\_\_\_\_

Side effects that need to be reported: \_\_\_\_\_

Starting Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Phone #: \_\_\_\_\_ License #: \_\_\_\_\_