DANVERS RECREATION

AUTHORIZATION TO ADMINISTER MEDICATION

Name: ____Birth Date: ____________________

Age: _____Sex: ______ Home Telephone #: _____________________Cell: ___________________________

Home Address: ____

Parent/Guardian: ____

Work Telephone: ____

In an emergency, notify:

1) Name: ____Telephone: _______________________________

2.) Name: ____Telephone: ______________________________

Medications to be taken during program hours or on an as needed basis:
Name(s):____
Diagnosis (at parent discretion):____
Name of medication: ____
Dosage: ____
Route of administration: ____
Frequency & time(s) to be given: ____
Side effects/Special precautions: ____
Specific directions (e.g., on empty stomach/water):____
Special storage requirements: ____

I hereby give my permission for Danvers Recreation Staff to administer above medication(s) to my son/daughter
(Name)____

I understand that all medications, prescription and/or over-the-counter, must be in their original containers, must be labeled, and have specific directions for use on the label. A prescription medication must include the prescription number, medication name, date filled, child's name, doctor's name, pharmacy name, and have the expiration date noted.

PARENT/GUARDIAN: ____DATE: ______________________