

**Melody Pines Day Camp, Inc.**  
PERMISSION TO ADMINISTER MEDICATION

Name of Child: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Symptom/Reason for Giving: \_\_\_\_\_

Prescribed By: \_\_\_\_\_

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

Hour to Administer: \_\_\_\_\_

Days of the week: M T W TH F (please circle)

To Be Refrigerated: Y or No (please circle)

To Be Returned Daily: Y or No (please circle)

Specific Instructions: \_\_\_\_\_

**ALL MEDICATIONS MUST BE DELIVERED IN THE  
ORIGINALLY LABELLED CONTAINER.**

**IF COMPLICATIONS WITH CONDITION OR  
MEDICATION OCCUR CONTACT:**

NAME: \_\_\_\_\_

PHONE (1): \_\_\_\_\_ PHONE (2): \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE:

\_\_\_\_\_