MEDICATION PERMISSION FORM

BRAINERD FAMILY YMCA
602 OAK ST.
BRAINERD, MN 56401

Camper Name _____

Camper Address _____
_____

I have prescribed the following medication for this child and request that dosage falling during camp hours be administered by camp personnel. (Authorization is requested for nonprescription medications also.)

Medication _____ Condition for which prescribed _____

Possible side effects _____

Instructions for use _____ Dosage _____ Time _____

Frequency _____ How long (# of days) _____

Date _____ Physician _____
Signature
_____
Address
_____
Phone

Pharmacy _____ Phone _____ RX# _____

I request that the above medication be given to my child as prescribed.

Date _____ Parent/Guardian Signature _____

BRAINERD YMCA CAMP STAFF: Fill in the date, time and initials whenever dispensing medication.

Monday	Tuesday	Wednesday	Thursday	Friday