Municipality of Clarington

Recreation Programs

MEDICATION CONSENT FORM

If the participant requires medication (prescribed or over the counter) during the program time, please complete the following form:

NOTE: PLEASE SEND THE DAYS DOSAGE ONLY IN THE ORIGINAL, PRESCRIBED CONTAINER.

Name of participant: _____ Camp Location: _____

Name of Medication	Dosage	Times Dispensed	Refrigeration Required

Please indicate when medication(s) is/are to be dispensed in relation to meals:

_____

Potential reactions or side effects: _____

Any other special instructions we should know:

_____

Name and phone number of prescribing doctor: _____

_____

I authorize the supervision only for dispensing of the listed medication by the Municipality of Clarington Recreation staff, with the understanding that there is not a qualified medical person at the program and the above-named participant must administer his/her own medication.
I agree to provide staff, on a daily basis, the daily prescribed dosage of medication only in the original prescribed container. With the following information; participant's name, name and phone number of doctor, name of the medication, dosage and time to dispense the medication.

_____ _____

Parent/Guardian Date