WASATCH KIDS MEDICATION RELEASE FORM

Name of Child: _____ Age: _____

Name of Medication: _____ Expiration Date: _____

Physician: _____

Dates to be Given: _____ Times to be Given: _____ Dosage: _____

Route of Administration (oral, topical, etc.): _____

Illness or Condition being treated: _____

Possible Side Effects or Drug Interactions: _____

I hereby give authorization for the Wasatch Kids Camps staff to administer the above medication according to the above instructions. I recognize that the staff will not be held liable for any illness or injury resulting from the administration of this medication, and will not be held responsible for reimbursement of medical expenses resulting from such action.

_____

(Signature of Parent or Guardian) (Date)

Date	Time	Dosage	Administered By	Errors in Administration	Reaction