Science Camps Medication Authorization Form

This form must be completed and signed by the **physician and parent** before any medication will be administered or permitted onsite during the Arboretum's Science Camp Program. *Please note that medication must be in an original container with pharmacy instructions and you may only bring enough medication for one day of camp at a time. **Upload Medication Authorization Forms Here**.

Camper Information:

Child's name: _____ Date of Birth: _____
Parent/Guardian Name_____ Phone: _____
Address: _____

I hereby request that The Morton Arboretum employees, volunteers and/or agents administer or supervise the administration of medication in accordance with the routine described under the Administrative Procedures for the Administration of Medication at The Morton Arboretum. ***Please note that medication must be in an original container with pharmacy instructions and you may only bring enough medication for one day of camp at a time.**

By signing below, I agree that I am primarily responsible for administering medication to my child. However, I authorize The Morton Arboretum, and its employees, volunteers and/or agents, on my behalf and in my stead, to administer to my child or to allow my child to self-administer while under the supervision of the employees, volunteers and/or agents of The Morton Arboretum, lawfully prescribed medication in the manner listed below. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than trained medical personnel and I specifically consent to such practices. I further acknowledge and agree that when the lawfully prescribed medication is so administered, I waive any claims I might have against The Morton Arboretum, and its employees, volunteers and agents, arising out of the administration of said medication. In addition, I agree to indemnify and hold harmless The Morton Arboretum, and its employees, volunteers and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or self-administration of said medication, except a claim based on willful or wanton conduct.

Parent/Guardian Signature_____ Date_____

Medication Information: TO BE COMPLETED BY THE PHYSICIAN

Diagnosis: _____ Medication: _____
Route of administration: _____ Dosage: _____
Time: _____ Side Effects: _____
Severe reaction that may occur to other children for whom medication is not prescribed should they receive a dose of the same:_____

_____

Date of prescription: _____ Discontinuation date: _____
The child may self-administer and/or self-carry medications with supervision or the medication may be administered/carried/stored by a staff member. The following describes the circumstances which indicate that medication should be administered: _____

_____

Other medication the child is receiving: _____
Annual re-evaluation is required. Please indicate if it should be sooner: _____

Physician Name (Print)_____ Phone_____
Physician Signature_____ Date_____

Science Camp Medication at Camp Policy can be found in the Science Camp Information Packet