AYCC Childcare & Camps
Phone: 207-873-0684
SEP: Rich Candido childcare@clubaycc.org
Camp Tracy: Pat Kearns camps@clubaycc.org

Medication Permission Form

Last Name _____

First Name _____

DOB _____ Prescribing Physician _____

Name of Medication(s) _____

Date of Medication Order _____ Dosage _____

Time & Frequency of Medication to be administered: _____

_____

Continue this medication until: _____ I have given the first dose on: _____

I hereby verify that _____(Child's Name) has a valid prescription for the medication(s) listed above.

Parent/Guardian Name _____

Phone _____ Email _____

Signature _____ Date _____

Date	Number of Pills & Dosage	Parent/ Guardian Initials	Staff Received	Date	Number of Pills & Dosage	Parent/ Guardian Initials	Staff Received

Child's Last Name _____ Child's First Name _____

Date	Number of Pills & Dosage	Parent/ Guardian Initials	Staff Received	Date	Number of Pills & Dosage	Parent/ Guardian Initials	Staff Received