

# West GYSTC Medication Authorization



I hereby give my permission for authorized personnel to administer to my child the medication listed below:

Child's Name: \_\_\_\_\_

Camp: \_\_\_\_\_

Medication Name: \_\_\_\_\_

**Please Circle One:**

Over the Counter Medication   or   Prescribed Medication

Amount to be given: \_\_\_\_\_

Time to be given: \_\_\_\_\_

This authorization will be in effect from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**If this is a prescribed medication, a copy of the Pharmacy label should be attached below:**