FORT WAYNE PARKS AND RECREATION DEPARTMENT
705 EAST STATE BOULEVARD, FORT WAYNE, INDIANA, 46805
TELEPHONE: 260-427-6000
FAX: 260-427-6020
www.fortwayneparks.org

PRESCRIPTION MEDICATION PERMISSION FORM

MEDICATION MUST BE BROUGHT IN THE ORIGINAL CONTAINER

PLEASE PRINT

CHILD'S NAME: _____ DOB: _____

MEDICATION: _____

REASON FOR MEDICATION: _____

FORM OF MEDICATION: ___TABLET/CAPSULE ___LIQUID ___INHALER ___EPIPEN
OTHER_____

INSTRUCTION: _____

START DATE: _____ STOP DATE: _____

___FOR EPISODIC/EMERGENCY EVENTS ONLY

PHYSICIAN'S NAME: _____ TELEPHONE: _____

I give permission for my child to receive the above prescription medication at the Fort Wayne Parks and Recreation Department's Day Camp. I understand that the person dispensing the medication may not be medically trained. I agree to inform the Fort Wayne Parks and Recreation Department's Supervisor(s) immediately of any changes relating to the medication or other medical information, including changes in when and if the medication is taken or any reaction to the medication. When the medication is discontinued or upon completion of the camp, I will pick all unused medication. Unclaimed medication may be discarded or destroyed.

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____