



PRESCRIPTION MEDICINE DISPENSING AUTHORIZATION

Metropolis of Atlanta Family Life Ministry Family Camp

Please complete this form and return to:

2480 Clairmont Rd., Atlanta, GA 30349 ATTN: Paula Marchman

email – paulamarchman@yahoo.com Phone 404-272-5775

All medication must be in original containers. All medications, prescription or non-prescription, must be accompanied with written dosage instructions and are the responsibility of parents to administer.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

MEDICATIONS: Please list all medications that your child(ren) will be taking while at camp.

<u>Medication</u>	<u>Dose</u>	<u>Frequency (circle)</u>	<u>Times to be given</u>
_____	_____	Daily / As Needed	_____
_____	_____	Daily / As Needed	_____
_____	_____	Daily / As Needed	_____
_____	_____	Daily / As Needed	_____

Do your children have any allergies to any other medicines that might be administered? (Tylenol, aspirin, Benadryl, anti-itch cream, etc.) _____

It is okay for the following over-the-counter medications to be administered to your children?

- | | |
|---|---|
| <input type="checkbox"/> Bismuth | <input type="checkbox"/> Ibuprofen (Motrin) |
| <input type="checkbox"/> Topical cream | <input type="checkbox"/> Calamine lotion |
| <input type="checkbox"/> Burn gel | <input type="checkbox"/> Ben-Gay |
| <input type="checkbox"/> Acetaminophen (Tylenol) | <input type="checkbox"/> Triple antibiotic ointment |
| <input type="checkbox"/> Diphenhydramine (Benadryl) | <input type="checkbox"/> Cough drops |
| <input type="checkbox"/> Antihistamine/decongestant | <input type="checkbox"/> Calcium antacid |

Parent or guardian's name: _____

Relationship to child: Mother Father Other (specify): _____

Phone where you can be reached during the day: _____

Signature of Guardian _____