



Medical Assistance Request Form

Child's Name: _____

Medication	Dosage Information (dates, time, amount, frequency)

Use back if more space is needed.

Other Pertinent information: _____

Use back if more space is needed.

I give permission for the KidsCamp Staff at Grey Roots to administer the medication as specified and directed to the child listed above.

I agree that it is my responsibility to bring the medication which shall be labeled with the name of the patient, the prescribing physician, the name of the medication, the dosage, frequency and duration of the medication. The request will expire on the last date stated above.

I understand that any staff person involved in these procedures is acting in the place of the child's guardian and not as a health professional.

Signature of the Parent/Legal Guardian

Date