



MEDICATION PERMISSION SLIP

Day Overnight ExplorAsian CIT Counselor Staff

NAME (LAST, FIRST): _____

DATE OF BIRTH (mm/dd/yy): _____

If your child uses an Epi Pen or inhaler, please bring two: one for the group Counselor and one for the Camp Nurse.

Medication: _____

Dose: _____

Frequency: _____

Route: _____

Medication: _____

Dose: _____

Frequency: _____

Route: _____

Medication: _____

Dose: _____

Frequency: _____

Route: _____

NO MEDICATION WILL BE ADMINISTERED WITHOUT A SIGNED PERMISSION SLIP

Over the Counter Medication

Must be in the original container

Prescription Medication

Must be in original container with pharmacy name, medication, dosage, how often to administer, route and prescribing doctor.

I, _____ give permission for qualified personnel under the direction of the
(parent/guardian)
New England Chinese Youth Summer Camp (NECYSC) to administer the medications listed above.

Parent/Guardian Signature: _____ Date: _____