

*MoLab, Inc. 's Camp Spark – Igniting Knowledge!*

# Authorization to Administer Medication Form

I hereby certify that it is necessary for \_\_\_\_\_  
\_\_\_\_\_ (Camper's First and Last Name)  
\_\_\_\_\_ to be given the medication listed below during camp hours.  
(Camp Session Dates)

Without this medication, he/she will not be able to attend camp.

***PLEASE NOTE THAT ONLY ORAL MEDICATIONS CAN BE ADMINISTERED BY CAMP STAFF***

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

Dosage to be given: \_\_\_\_\_

Form of Medication (liquid, tablet, etc.): \_\_\_\_\_

Time of Administration: \_\_\_\_\_

Beginning Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_

Side Effects: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Emergency Telephone Numbers:

Parent/Guardian: \_\_\_\_\_ Work #: \_\_\_\_\_ - \_\_\_\_\_ Home #: \_\_\_\_\_ - \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Work #: \_\_\_\_\_ - \_\_\_\_\_ Home #: \_\_\_\_\_ - \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ - \_\_\_\_\_

**It is understood by the undersigned that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances.**

\_\_\_\_\_  
(Parent/ Guardian Signature)

\_\_\_\_\_  
(Date)

*Parents are requested to pick up any leftover medication by the last camp session date. Medicine left after this time will be discarded.*

**Mail to: MoLab, Inc. Camp Spark – Igniting Knowledge!**  
**1700 North Monroe Street, Ste 11-223**  
**Tallahassee, FL 32303**  
**Email to: [aimee@tallymolab.org](mailto:aimee@tallymolab.org)**