EAST WEST TAE KWON DO CAMP
Authorization for the Administration of Medication

STUDENT NAME _____ DATE OF BIRTH _____

ADDRESS: _____ CELL PHONE: _____

_____ WORK PHONE: _____

I. MEDICATION
The medication must be in it's original container bearing a pharmacy label which shows the prescription number, date filled, side effects, prescribing physician's name, name of medication, directions for taking the medication, and the patient's name.

II. PHYSICIAN'S STATEMENT:
1. Name/type of medication_____
2. Dosage/amount to be given_____
3. Frequency/times to be administered_____
4. Duration (week, month, indefinite, etc.)_____
5. Anticipated reaction to medication (symptoms, side effects, etc.)_____

_____

_____

PHYSICIAN'S SIGNATURE Address Phone Date

III. PARENT'S REQUEST/APPROVAL
I hereby request and give my permission for East-West Tae Kwon Do to administer the medication prescribed on this form to my child.

_____

PARENT/GUARDIAN SIGNATURE Date

IV. DESIGNATED PERSON(S) ADMINISTERING DRUGS
I have agreed to administer the medication as requested by the parents and in accordance with directions listed above by the physician.

_____

SIGNATURE OF PERSON(S) ADMINISTERING MEDICATION Date