



# MEDICINE ADMINISTRATION FORM

## MEDICINE ADMINISTRATION

<input type="checkbox"/> SUMMER CAMP / RESPITE	<input type="checkbox"/> DAY CAMP	<input type="checkbox"/> SCHOOL GROUP	
<b>PARTICIPANT</b>			
First name		Last name	
Birth date		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Health insurance number		Expiry date	
<b>MEDICATION</b>			
Name of medication	Reason	Schedule	Dosage (mg or ml)
<b>Comments</b> (if dosage is "as needed" please elaborate)			
<b>AUTORIZATION</b>			
I acknowledge that the information described above is correct and I authorize the person in charge of health care, or his or her agent if any, to administer medications at the dosage and frequency indicated.			
Name of parent or guardian	Parent or guardian's signature	Date	
<b>Administration use only</b>			
Chalet:		Monitor:	
Notes:			



À L'ÉTAT *naturel*

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