CENTRE-NOTRE-DAME-DE-FATIMA

DRUG ADMINISTRATION

☐ SUMMER CAMP / RESPITE	☐ DAY CAMP	☐ SCHOOL GROUP

PARTICIPANT			
First name		Last	
Date of birth		Gender	☐ Male ☐ Female
Health ins. number		Exp.	

MEDICATION

Name of medication	Reason	Hour	Dosage (mg or ml)

Comments (if dosage is “as needed” please provide explanation)

AUTORIZATION

I acknowledge that the information above is true and I authorize the person in charge of health care, or its agent if necessary, to administer medications according to the dosage and frequency indicated.

Name of parent or tutor	Parent or tutor’s signature	Date

Administration use only

Chalet:	Monitor:
Notes:	