West GYSTC Medication Authorization

I hereby give my permission for authorized personnel to administer to my child the medication listed below:

Child's Name: _____

Camp: _____

Medication Name: _____

Please Circle One:

Over the Counter Medication or Prescribed Medication

Amount to be given: _____

Time to be given: _____

This authorization will be in effect from _____ to _____

_____ _____

Parent/Guardian Signature Date

If this is a prescribed medication, a copy of the Pharmacy label should be attached below: