CENTRE-NOTRE-DAME-DE-FATIMA

DRUG ADMINISTRATION

☐ SUMMER CAMP / RESPITE					
PARTICIPANT					
First name		Last			
Date of birth		Gender	☐ Male ☐ Female ☐ Other		
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:					