



# Cedardale / Groveland Summer Day Camp

P.O. Box 16  
20 Bare Hill Rd.  
Groveland, M.A. 01834

## Permission Form for Prescribed Medication.

Camper Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Group \_\_\_\_\_

To be completed by Physician or Authorized Provider

Name of Medication; \_\_\_\_\_

Reason for Medication; \_\_\_\_\_

Form of Medication;  Tablet/Capsule  Inhaler  Injection  Nebulizer  Other

Instructions (Time to be administered and dose); \_\_\_\_\_

Restrictions and/or Side Effects; \_\_\_\_\_

Special Storage Requirements; \_\_\_\_\_

Physicians Signature; \_\_\_\_\_ Physicians Name; \_\_\_\_\_

Address; \_\_\_\_\_ Phone Number; \_\_\_\_\_

Pursuant to 105 CMR 430.159 and 105 CMR 430.160, Cedardale/Groveland permits a camper to possess and self-administer asthma or anaphylaxis medication at camp upon completion of the following information by the parent/guardian and the camper's physician and waiver of liability by the parent/guardian.

This camper has been instructed on self-administration of this medication, to be completed for asthmatic, diabetic, or severe allergic reaction (anaphylaxis) ONLY.

No  Supervision Required  Supervision NOT Required

The camper may carry this medication  Yes  No

Additional information is provided on the back of this form.

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

To be completed by Physician or Authorized Provider

I give permission for (name of child) \_\_\_\_\_ to receive the above stated medication at camp according to standard policy. I release Cedardale/Groveland Summer Day Camp and its employees from any claims or liability connected with its reliance on this permission.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_