

FORT WAYNE PARKS AND RECREATION DEPARTMENT
705 EAST STATE BOULEVARD, FORT WAYNE, INDIANA, 46805
TELEPHONE: 260-427-6000
FAX: 260-427-6020
www.fortwayneparks.org

OVER THE COUNTER MEDICATION PERMISSION FORM

MEDICATION MUST BE BROUGHT IN THE ORIGINAL CONTAINER

PLEASE PRINT

CHILD'S NAME: _____ **DOB:** _____

MEDICATION: _____

REASON FOR MEDICATION: _____

FORM OF MEDICATION: ___ TABLET/CAPSULE ___ LIQUID ___ INHALER ___ OTHER _____

INSTRUCTION: _____

START DATE: _____ **STOP DATE:** _____

___ **FOR EPISODIC/EMERGENCY EVENTS ONLY**

PHYSICIAN'S NAME: _____ **TELEPHONE:** _____

I give permission for my child to receive the above over the counter medication at the Fort Wayne Parks and Recreation Department's Day Camp. I understand that the person dispensing the medication may not be medically trained. I agree to inform the Fort Wayne Parks and Recreation Department's Supervisor(s) immediately of any changes relating to the medication or other medical information, including changes in when and if the medication is taken or any reaction to the medication. When the medication is discontinued or upon completion of the camp, I will pick all unused medication. Unclaimed medication may be discarded or destroyed.

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____