



Medication Authorization Form

Camper Name: _____ Camper Age: _____

Guardian Name: _____ Guardian Phone Number: _____

Guardian Address: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Emergency Contact Address: _____

Campers Physician: _____

Camper Physician Phone Number: _____

Winter Arts Camp Session (Check One):

AM Session _____

PM Session _____

Full Day Session _____

Name of Medication: _____

Dose given at camp: _____

Frequency: _____

Expiration date of Medications Received: _____

Special Storage Requirements: _____

Specific Directions (e.g., with water, on empty stomach): _____

Specific Precautions: _____

Possible Side Effects / Adverse Reactions: _____

Other Medications (at parents discretion): _____

I hereby authorize the Everson Museum of Art to administer to my _____
child, the medication(s) listed above.

Guardian Signature: _____