DURHAM ACADEMY SUMMER PROGRAMS
PRESCRIPTION MEDICATION CONSENT FORM

NOTE TO DURHAM ACADEMY SUMMER PROGRAM PARENTS: In order to help protect your child's health, your consent and written authorization is required when it is necessary for your child to receive prescription medications. For each prescription medication you wish Durham Academy Summer Programs to administer to your child while he/she is at camp, you must sign and date this form.

Camper's Name: ____ Birthdate: ____________________

Camp: ____________________________________

I authorize Durham Academy Summer Programs' Health and Safety Coordinator to administer to my child identified above the prescription medication listed below in accordance with the instructions stated below. I understand that it is my responsibility to purchase and supply this medication in its **original packaging/container**, including refills as necessary. I will inform the Health and Safety Coordinator immediately should my child's healthcare provider change the instructions for the administration of such medication.

Based on the recommendation from my child's medical provider, I confirm that it is medically necessary for the camper identified above to receive the following medication during camp hours in order to maintain or improve health and to benefit from camp attendance. The below medication should be provided to the camp in its original packaging/container, and should be administered in accordance with the instructions stated on the container, unless otherwise stated below.

I hereby waive, release, discharge, and agree to save, defend, indemnify, and hold harmless Durham Academy Summer Programs from all claims of any kind whatsoever, at law or in equity, including but not limited to claims based on any injuries or damages to person, relating in any way to any act or failure to act relating to this authorization.

Parent/Guardian Signature: ____ Date: ______________

Telephone Numbers: ____

Medication: ___________________________________ Diagnosis: ____________________________

Strength/dose: ___________________________________ Time of administration: ______________

Other Instructions or Directions, if any: ____

Name of Prescribing Healthcare Provider: ____

Healthcare Provider's Office Address: ____

Telephone Number: ______________________________