dayamprogram VISTARECREATION.COM

Medication Release Form

I hereby request that the City of Vista Day Camp Program staff administer medication to my child/ward as prescribed by a physician licensed under the laws of the State of California. All medication and information will be properly secured in the office and only accessible by the necessary camp staff.

Child's Name: _____ Date: _____

Medication	Dosage	Time	Special Notes/Possible Reactions

Prescribing Physician: _____ Phone: _____

Additional Notes for Camp Staff

_____

_____

_____

Waiver: I agree to indemnify, defend and hold harmless the City of Vista, a chartered municipal corporation, its officers, agents, and employees from any injury or expense arising out of or resulting from any reaction which my child/ward may suffer as a result of taking the medication(s) previously indicated. I understand that all medication must be in a prescription bottle with the prescribing physician's name, medication will not be accepted in any other container, and children may not medicate themselves. I also understand that medication left after the end of the season will be properly disposed of.

_____ _____

Parent Signature *Date*

OFFICE USE ONLY

DATE	MEDICATION	DOSAGE	TIME	STAFF INITIALS

Season: ❑ Summer ❑ Winter ❑ Spring

Disposal Date: _____