

Child's Name: _____ Location: _____

**Collier County Parks and Recreation Department
MEDICATION AUTHORIZATION FORM**

Child's Name: _____

Medication: _____

Dosage (Amount): _____

Time(s) Given: _____

Medication Instructions and Possible Side Effects: _____

Any conditions that your child has that we should be aware of: _____

- **Medication must be in original container and properly labeled. Prescription medication must have the following information on the label:**

1. Doctor's Name
2. Child's Name
3. Medication Directions

Parent/Guardian Signature

Printed Name of Parent/ Guardian