**Medication Administration Release Form**

Camper's Name: _____ DOB: _____ Age: _____

Height: _____ Weight: _____ Gender: Male Female (please circle)

Home Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____

Cell Phone: _____

**This form authorizes New Hope for Kids' personnel to administer prescription/over-the-counter drugs to the above listed child or adult if needed. Parent/Responsible adult attending will administer at appropriate times. Please list any medications that will be administered to the above listed camper while at Camp Ray of Hope-Disney World.**

| Name of Medication | For Treatment Of | Dosage | Times | Prescribing Doctor |
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**Signature of Parent/Guardian**_____ **Date:** _____