True Light Fellowship Summer Day Camp
6400 Ardleigh Street ~ Philadelphia, PA 19119
(215) 548-5053 ~ FAX (215) 548-3732 ~ WEBSITE: truelightfellowship.org
Dr. Wesley Pinnock, *Senior Pastor & Founder* * Pastor Derrick Johnson, Sr., MBA, CPA , *Administrator*
Beverly A. Burrows, MBA, *Director* * *Shelly Campbell, Asst. Director*, * Lisa Williams, BS. and Muriel James, *Registrars*

TLF Day Camp Ministries Medication Authorization Form

Camper's Name _____ DOB _____

Address _____ Apt.# _____

City _____ State _____ Zip Code _____

Cell Phone _____ Home Phone _____

========== **PERSON(S) AUTHORIZED TO PICK UP YOUR CHILD** ==========

Name _____ Relationship _____

Address _____ Apt. # _____

City _____ State _____ Zip Code _____ Tel# _____

Name _____ Relationship _____

Address _____ Apt. # _____

City _____ State _____ Zip Code _____ Tel# _____

========== **LOCAL PHILADELPHIA EMERGENCY CONTACT** ==========

Name _____ Relationship _____

Address _____ Apt. # _____

Cell Phone _____ Home Phone _____

Name _____ Relationship _____

Address _____ Apt. # _____

Cell Phone _____ Home Phone _____

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, or in the event of a medical emergency, I hereby authorize the True Light Fellowship Day Camp Ministries' camp employees and/or agents, in my behalf, to administer or to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and/or agents of the True Light Fellowship Day Camp Ministries), lawfully prescribed medication in the manner described by the child's physician and/or parent/guardian.. I also acknowledge and give consent, in an emergency, that it may be necessary for the administration of medications to my child be performed by an individual other than the employees or agents of the True Light Fellowship Day Camp Ministries. I agree to indemnify, not hold liable, and hold harmless the True Light Fellowship Day Camp Ministries and its employees and/or agents against any claims arising out of the administration of medicines/medication or the child's self-administration of medication.

_____ _____

Parent/Guardian **printed** name Date Parent/Guardian **Signature** Date

Witness Verification _____ Title _____ Date _____

TO BE COMPLETED BY THE CAMPER/CHILD'S PHYSICIAN

Physician's printed name: _____

Office Address: _____

Office Phone: _____ Emergency Phone: _____

Medication Name: _____ Purpose: _____

Dosage: _____ Frequency: _____

Time medication is to be administered or under what circumstances: _____

_____

Prescription Date: _____ Order Date: _____ Discontinuation Date: _____

Diagnosis requiring medication: _____

Is it necessary for this medication to be administered during the time the camper attends Camp?_____

Expected side effects, if any: _____

Time interval for re-evaluation: _____

Is the child receiving any other kinds of medication? If so, what? _____

_____

Physician's signature Date

TO BE COMPLETED BY THE CAMPER/CHILD'S PARENT OR GUARDIAN

Camper's Name _____ DOB _____

Address _____ Apt.# _____

City _____ State _____ Zip Code _____

Cell Phone _____ Home Phone _____

I authorize the True Light Fellowship Day Camp Ministries employees and/or agents, to allow my child or ward to possess and use his/her asthma medication and/or epinephrine auto-injector, or other prescribed medications while at the camp or a camp sponsored activity. By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, or in the event of a medical emergency, I hereby authorize the True Light Fellowship Day Camp Ministries' camp employees and/or agents, in my behalf, to administer or to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and/or agents of the True Light Fellowship Day Camp Ministries), lawfully prescribed medication in the manner described. I also acknowledge and give consent, in an emergency, that it may be necessary for the administration of medications to my child be performed by an individual other than the employees or agents of the True Light Fellowship Day Camp Ministries. I agree to indemnify, not hold liable, and hold harmless the True Light Fellowship Day Camp Ministries and its employees and/or agents against any claims arising out of the administration of medicines/medication or the child's self-administration of medication.

_____ _____

Parent/Guardian **printed** name Date Parent/Guardian **Signature** Date

Witness Verification _____ Title _____ Date _____