

TRIPLE-A SUMMER CAMP

IF APPLICABLE, PLEASE RETURN WITH YOUR PAYMENT

2025 Medication Form

1004 Tuckerton Rd, Marlton, New Jersey 08053

MEDICATION

I request the enclosed medication(s), **in its original container(s)**, be administered to my child and I shall release all Township of Evesham personnel from any and all liability related to the submitted medication.

Camper's Name: _____

Name of Medication: _____ Dosage: _____ Purpose: _____

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With my signature, I acknowledge reading and agree to comply with the Medication Policy of 2025 Triple-A Summer Camp.

Parent/Guardian (Please Print)

Parent/Guardian Signature

Date

PHYSICIAN'S ORDERS

Patient's Name _____

Name of Medication(s): _____

Date of Prescription(s): _____

Dosage(s): _____

Purpose (s): _____

Comments: _____

If applicable:

I have instructed and approve the above patient to self-administer their rescue inhaler or EpiPen.

Doctor's Name (Please Print)

Doctor's Signature

Date