Consent For Administration Of Medication During Seizure

In the event that my son/daughter is having a seizure lasting for more than
And is unable to administer the following medication, I/We hereby authorize and instruct the Town of Newmarket, its employees and agents to administer the following medication to my child:

Camper Information	
Child's Name:	
Date:	
Camp Attending	
Week of Camp:	
Date of Birth:	
Health Card #:	

- ☐ Parent is to be contacted when any seizure occurs
- ☐ Parent is to be contacted when medication is required
- ☐ 911 is to be called when medication is administered
- ☐ 911 is to be called when

Description of Seizure Activity		
What Seizure looks like	Length of time	Action to be followed

Medication Information	
Medication Administered:	
Dosage:	
Administer When:	
Insturction for Administration	
Location and Storage of Medication:	