BREEZEMONT DAY CAMP
P.O. BOX 858, ARMONK, NY 10504
914.273.3162

MEDICATION ORDER FORM

THE MEDICATION FORM (AT THE BOTTOM) MUST BE SIGNED BY A PARENT OR GUARDIAN AND BY THE PRESCRIBING PHYSICIAN. THIS FORM MUST BE COMPLETED BEFORE THE NURSE CAN ADMINISTER ANY MEDICATION TO A CAMPER. PLEASE NOTE: ALL MEDICATIONS MUST BE SENT TO CAMP BY A PARENT OR GUARDIAN. IF NOT A "CONTROLLED" MEDICATION IT MAY ALSO BE GIVEN TO THE BUS COUNSELOR FOR TRANSPORT. IT IS AGAINST CAMP POLICY TO ALLOW CHILDREN TO CARRY MEDICATION TO OR FROM CAMP, OR WHILE AT CAMP. CHILDREN NEEDING MEDICATION FOR ALLERGY OR ASTHMA MUST RECEIVE THE MEDICAITON IN THE NURSE'S OFFICE. **YOU MAY FAX THE COMPLETED FORM TO (914) 273-5438** OR MAIL TO THE CAMP DIRECTLY. PLEASE RETURN BEFORE THE FIRST DAY OF CAMP.

ADMINISTRATION OF MEDICATION

The medication administration policy is consistent with NY State guidelines, accepted medical practice and children's safety. MEDICATIONS MUST BE DELIVERED TO THE **CAMP** AND TAKEN HOME BY A PARENT OR GUARDIAN ONLY. **THERE WILL BE NO EXCEPTIONS.** It must be in a PRESCRIPTION bottle with a pharmacist's label attached. Over the counter medication is to be labeled with the child's name and must be in an unopened container.

If you wish the camp nurse to administer your child's medication during camp house, we require that this form be completed & returned to the nursing office. Thank you for you cooperation. Both sections must be completed **ANNUALLY**.

TO BE COMPLETED BY PARENT/GUARDIAN:
I hereby request that the camp nurse administer medication as prescribed by my child's physician.

Camper's Name:____________________ DOB:____________

Parent/Guardian's home phone:(_____) ___________________________

I hereby release **Breezemont Day Camp** from any and all liability arising from the administration of this medication.

TO BE COMPLETED BY THE PHYSICIAN FOR EVERY MEDICATION (prescription & over the counter)
Patient Name: ________________________ Diagnosis:_________________

Medication:_________________ Dose:_______________ Frequency:_________

Dates for administration: From_________Through:_________

If PRN, signs & symptoms for administering medication:____

Possible Side Effects:____

Restrictions (Be Specific):____

Print M.D. name, address & phone:
____
____
____

M.D. signature:____________________________ Date:_______________ NYS Reg #________________