TOWN OF NORTH CASTLE
Parent & Physician's Authorization For
Administration of Medications in Camp/Camp Activities

!! <u>If your child takes / has medications in school, they should also have them for camp; medications MUST be in camp by the child's first day attending</u> !!

TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child _____, date of birth _____ receive the medication prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

Signature of Parent/Guardian _____

Home Phone _____ Cell Phone _____

Email _____ Date _____

TO BE COMPLETED BY THE PHYSICIAN:

I request that my patient listed below receive the following medication;

Patient _____ D.O.B. _____

Diagnosis _____

Medication	**Dosage**	**Frequency/Time To Be Taken**	**Route Adm.**	**Medication Exp. Date**
				/ /
				/ /
				/ /
				/ /

Duration of treatment _____

Possible side effects and adverse reactions (if any) _____

PLEASE CHECK ONE:

____I deem this child to be self-directed and understand that the camp nurse, or the designated person in case of the absence of the camp nurse, will supervise the administration of this medication, including field trips.

____I deem this child to be non self-directed and understand that the administration of oral, topical, inhalant and injectable medications must remain the responsibility of the camp nurse, licensed practical nurse or trip director under the direction of the camp nurse, physician or parent.

Physician's Signature _____ Date _____

Address _____ Phone _____

**Medication must be in original pharmacy-labeled container with specific orders and name of medication. Medication must be picked up by parent at the end of camp session.*