

DRIFTWOOD DAY CAMP

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REQUEST FOR ADMINISTRATION OF MEDICINE - 2017

This form must accompany all medications (Over-The-Counter and Prescriptions) that are kept and administered at camp.

DO NOT RETURN THIS FORM UNLESS ACCOMPANIED BY ANY MEDICATIONS

IN ORDER FOR MEDICATIONS TO BE ADMINISTERED AT DRIFTWOOD DAY CAMP, STATE LAW REQUIRES THAT WE RECEIVE A WRITTEN REQUEST FROM YOUR FAMILY PHYSICIAN WHICH IS SIGNED BY BOTH PHYSICIAN AND PARENT. THE FORM MUST SHOW THE FREQUENCY, DOSAGE, AND SIDE EFFECTS, AND MUST BE ON FILE.

CHILD'S FIRST NAME: _____ **LAST NAME:** _____

TO BE COMPLETED BY A PARENT OR GUARDIAN:

I REQUEST THAT DRIFTWOOD DAY CAMP ADMINISTER THE MEDICATION(S) REQUESTED BY MY PHYSICIAN TO MY CHILD. I WILL DELIVER THE MEDICATION(S) DIRECTLY TO DRIFTWOOD DAY CAMP IN A CONTAINER LABELED BY THE PHARMACIST WHICH INCLUDES THE NAME AND DOSAGE OF THE MEDICATION.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

TO BE COMPLETED AND SIGNED BY THE PHYSICIAN:

DIAGNOSIS	Medicaton: Prescription or over-the-counter	Strength/ Dosage	Frequency	Side Effects To Expect or Report	Special Dispensing Instructions

PHYSICIAN'S SIGNATURE & STAMP: _____ **DATE:** _____