Village of Briarcliff Manor Recreation Department

PERMISSION FOR MEDICATION AND SELF ADMINISTRATION

Name of Camper _____ DOB: ___/___/___ Camp Attending_____

Address _____

Mother's Name_____ Daytime # _____ Alt. #_____

Father's Name_____ Daytime # _____ Alt. #_____

Emergency Contact: _____Best # _____ Relationship _____

MEDICAL INFORMATION

Physician Name _____ Physician Phone _____

Health Insurance Carrier _____ Policy/ID # _____

TO BE COMPLETED BY PHYSICIAN OR PRESCRIBED LICENSED HEALTH CARE PROVIDER

All medications must be in original container with original prescription label and date of expiration.

Child's Diagnosis _____

Medication (Active Ingredient) _____ Dosage_____ Frequency _____

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If medication is to be given "as needed" please circle symptoms:

Mouth: Itching, swelling of lips, tongue or mouth, mouth feels "hot"
Throat: Itching, tightness in throat, hoarseness, cough
Skin: Hives, itchy rash, swelling of face and extremities
Stomach: Nausea, abdominal cramps, vomiting, diarrhea
Lung: Shortness of breath, repetitive cough, wheezing
Heart: rapid heart rate, feeling of passing out
Other:_____

Camper Photo

Action to be taken: _____

Possible side effects: _____

How often can each medication be repeated?_____

Additional Information: _____

Please check one:

_____I request that my child's prescription medication be securely stored in the camp office under the supervision of the camp staff. I certify that my child has been instructed and is capable of proper self-administration of the medication.

____ I request that my child be permitted to carry his/her prescribed medication (epi-pen/inhaler only) at camp. I certify that my child has been instructed and is capable of proper self-administration of the medication. I understand that if my child is using this medication unsafely, irresponsibly or fails to keep it out of reach from other campers, he/she will be taken to the camp office immediately and a parent/guardian will be called. I understand that the Village of Briarcliff Manor Recreation Department is not responsible for lost, stolen or improperly discharged medication.

I give permission to the onsite medical designee to observe the above named camper while self-administering the above mentioned medications and if necessary to seek emergency treatment at a hospital emergency room via Briarcliff Manor Volunteer Ambulance Corp.

_____	_____	_____
Signature of Parent/Guardian	Printed name of Parent/Guardian	Date
_____	_____	_____
Signature of Child's Physician	Printed name/STAMP of Physician	Date