Form 1

Please staple all pages together

1a

RESIDENTIAL CAMP
PRESCRIPTION AND OVER THE COUNTER MEDICATION FORM

THE FOLLOWING FORM MUST BE COMPLETED BY ALL PARENTS OF CHILDERN ATTENDING THIS CAMP AND SUBMITTED AT CHECK-IN

If your child will be taking medication while at camp, it is state law to secure your consent for medication distribution and for the use of medical devices. In addition to your consent, the prescribing physician must provide sign off on all medications, including over-the-counter medications, to be used at camp.

CAMPERS INFORMATION	
Child's Name	
Child's Age	
Host Camp Location	
Camp Dates	

Will your child require medication(s) while at camp? This includes EpiPens, Inhalers and Over-the-Counter medications. (Check appropriate box)

Yes		If "Yes", please complete the included Medication Form with your child's physician and submit it to the Health Director at camp check-in.
No		If "No" is answered, your child must not be in possession of **ANY** medication at camp. You only need to complete and sign page one of this form.

Will the camper be carrying FDA approved sunscreen? If so please select YES to provide parental/guardian permission to carry the sunscreen. If no is selected the camper will not be permitted to carry sunscreen in their bags. Campers must be able to apply
Yes ( ) No ( )

Campers are **NOT ALLOWED** to hold onto medication while at camp. **ALL** medications must be submitted with this accompanying document to the Health Director of the camp for proper storage and administration. If your child is found in possession of medication, either prescription or over-the-counter medication, parents will be called for immediate pick up from camp. At camp check-in, **ALL** prescription and over-the-counter medications along with this from must be submitted to the Health Director. Prescription medications must be in their **original containers** bearing the pharmacy label and have specific instructions for use (Child's name, dosage, # pills inside, prescribing practitioner, pharmacy name & address, filler's initials, serial #). Important: Due to Department of Health Regulations "as needed" medication must include a dosage and frequency and will only be given "as needed" with parental approval which will be obtained via a phone call. If the parent does not provide approval the camper will not be permitted to take the medication.

PARENT/GUARDIAN INFORMATION	
Parent/Guardian Name	
Parent/Guardian Signature	
Date	

Self-Administration: A self-administration process is used on NY residential camp programs. Self-administration of medications will **only** be allowed for those individuals determined to be "self-directed". Determination as to whether or not a camper should be considered for self-administration will be conducted by the Health Director or designee and will be based on the camper's ability to:

- Identify the correct medication (e.g., color, shapeIdentify the purpose of the medication (e.g., to improve attention),
- Determine that the correct dosage is being administered (e.g., one pill),
- Identify the time the medication is needed (e.g., lunch time, before/after lunch),
- Describe what will happen if medication is not taken (e.g., unable to pay attention), and

RESIDENTIAL CAMP
PRESCRIPTION AND OVER THE COUNTER MEDICATION FORM

- Refuse to take medication if camper has any concerns about its appropriateness.

In the event that the Health Director determinies the child cannot self-administer, medication will not be provided for self-administration and the child's parents will be called for child pick up. In general campers will not be allowed to self-administer "as needed" (PRN) medications, except for emergency medications such as inhalers and epinephrine auto-injectors, or when directed by the camper's physician and/or parent.

Over-The-Counter Medication

CAMPER INFORMATION	
Child's Name	
Child's Age	
GROUP INFORMATION (TO BE COMPLETED BY CAMP DIRECTOR)	
Assigned Coach	
Group Color	
Camp Dates	

IMPORTANT NOTE: Over-The-Counter (OTC) medications must be in their **original containers** bearing the original label and have specific instructions for use (Child's name, dosage amount and frequency, prescribing practitioner).

Will your child require Over-The-Counter (OTC) medication at camp? (Check appropriate box)

Yes		If "Yes", please complete the below for all OTC medications your child will require while at camp.
No		If "No" is answered, your child must not be in possession of **ANY** OTC medication at camp.

IMPORTANT NOTE: If your child requires any OTC medication while at camp, it is **required by law** that a prescription be written and provided at camp check-in for each OTC medication.

OTC Medication Name	Yes	No	Internal or External	Refrigeration Required (Y/N)	Prescription Provided
Benadryl					
Advil					
Tylenol					
Excedrin					
Claritin					
Pepto-Bismol					
Dimetapp					
Cortaid					
Midol					

If your player's OTC medication is not included in the list above, please enter the name of the medication in the table below:

OTC Medication Name	Yes	No	Internal or External	Refrigeration Required (Y/N)	Prescription Provided

1c

RESIDENTIAL CAMP
PRESCRIPTION AND OVER THE COUNTER MEDICATION FORM

EPIPENS

EpiPens must be submitted to the Health Director at camp check-in along with this accompanying document. Only if specifically authorized by the parent will the camper be allowed to hold the EpiPen, however, the Health Director must still be made aware of the presence of the EpiPen.(It is the camps preference for the Health Director to store all EpiPens).

CAMPER INFORMATION	
Child's Name	
Child's Age	
GROUP INFORMATION (TO BE COMPLETED BY CAMP DIRECTOR)	
Assigned Coach	
Group Color	

Will your child require an EpiPen at camp? (Check appropriate box)

Yes		If "Yes", please complete the section below.
No		If "No" is answered, your child must not be in possession of **ANY** EpiPens at camp.

If yes, what is the reason the camper requires an EpiPen? _____

Is the child prescribed by a doctor to self-administer the EpiPen? If "Yes", circle Y or N in response to whether a prescription was provided.

Yes		Prescription Provided	(Y / N)
No			

Prescribing Physician's Information

Physician Name	
Office Address	
Office Contact Number	
Physician's Signature	

Post Camp Action - To be completed by Camp Staff

EpiPen – Following camp the EpiPen must be returned to the parent or destroyed. (Check appropriate box)

Returned to Parent	
Destroyed	

1d

RESIDENTIAL CAMP
PRESCRIPTION AND OVER THE COUNTER MEDICATION FORM

Prescription Medication (#1)

CAMPER INFORMATION	
Child's Name	
Child's Age	
GROUP INFORMATION (TO BE COMPLETED BY CAMP DIRECTOR)	
Assigned Coach	
Group Color	

IMPORTANT NOTE: Prescription medications must be in their **original containers** bearing the pharmacy label and have specific instructions for use (Child's name, dosage, # pills inside, prescribing practitioner, pharmacy name & address, filler's initials, serial #).

Medication #1

Medication Name	
Expiration Date	
Condition for Use	
Amount/Dosage	
Time/Frequency	
Instructions for use? How is it administered?	
Internal or External medication?	
Does it require refrigeration?	
Side Effects, if any	

Prescribing Physician's Information

Physician's Name	
Office Address	
Office Contact Number	
Physician's Signature	

Medication #1 Self Administration Log (To be completed by Health Director at time of administration)

Date	Time	Dosage	Health Director's Signature	Parent Approval - PRN Meds

Post Camp Action - To be completed by Camp Staff

Medication #1 – Following camp the medication must be returned to the parent or destroyed. (Check appropriate box)

Returned to Parent	
Destroyed	

1e

RESIDENTIAL CAMP
PRESCRIPTION AND OVER THE COUNTER MEDICATION FORM

Prescription Medication (#2)

CAMPER INFORMATION	
Child's Name	
Child's Age	
GROUP INFORMATION (TO BE COMPLETED BY CAMP DIRECTOR)	
Assigned Coach	
Group Color	

IMPORTANT NOTE: Prescription medications must be in their **original containers** bearing the pharmacy label and have specific instructions for use (Child's name, dosage, # pills inside, prescribing practitioner, pharmacy name & address, filler's initials, serial #).

Medication #1

Medication Name	
Expiration Date	
Condition for Use	
Amount/Dosage	
Time/Frequency	
Instructions for use? How is it administered?	
Internal or External medication?	
Does it require refrigeration?	
Side Effects, if any	

Prescribing Physician's Information

Physician's Name	
Office Address	
Office Contact Number	
Physician's Signature	

Medication #1 Self Administration Log (To be completed by Health Director at time of administration)

Date	Time	Dosage	Health Director's Signature	Parent Approval - PRN Meds

Post Camp Action - To be completed by Camp Staff

Medication #1 – Following camp the medication must be returned to the parent or destroyed. (Check appropriate box)

Returned to Parent	
Destroyed	

Please make additional copies of this form if more than two medications are being submitted