ALL SPORT CAMP FIT

17 OLD MAIN STREET, FISHKILL, NEW YORK 12524
TELEPHONE: (845) 896-5678 FAX: (845) 896-8595

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS

The Dutchess County Health Department requires a physician's written order and parent or guardian's authorization for a nurse, first-aider, the camp director, program director or camp counselor to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, physician's name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.

PHYSICIAN'S ORDER: **Date: ___/___/___**

Name of Child:_____Date of Birth: ___/___/___

Street Address:_____City/Town_____State_____

Condition for which drug is being administered during camp hours:_____

_____

DRUG: Name of drug, Dose & Method of Administration:_____

_____

When should medication be administered: Date___/___/___-___/___/___ Time: _____ PRN ☐

Relevant side effects to be observed, if any:_____

_____

If there are side effects, plan for management:_____

_____

Is this a controlled drug?_____

Allergies to food or drugs? Yes/No If yes, list:_____

Physician's/Dentist's Name:_____Phone #:_____
(Type or print)

Street Address:_____City/Town_____State_____

Physician's Signature: _____

Authorization by Parent/Guardian for the administration of the above medication:

Date: ___/___/___

To camp director, first aider, program director or camp counselor:

I hereby request that the above named medication, ordered by the physician/dentist for my child, be administered by the camp director, first-aider, program director or camp counselor.

I understand that I must supply Camp Fit with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name.

I understand that this medication will be destroyed if it is not picked up within one (1) week following termination of the order.

Name of Parent or Guardian:_____Signature:_____

Relationship to child: _____ Phone: _____