Ardsley Day Camp
700 Ashford Avenue
Ardsley, NY 10502
Sean Grady, Director

Health Office
914-295-5690

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN CAMP

Part A. TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that my child _____, grade _____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that this includes all over-the-counter medications as well as prescription medications. The medication is to be brought by me to the health office and NOT SENT WITH MY CHILD. The camp nurse will administer the medication.

Parent or Guardian Signature: _____ Date: _____
Phone #: Home_____ Work_____ Cell _____

Part B. TO BE COMPLETED BY LICENSED HEALTH CARE PRESCRIBER:

Name of Camper: _____ Date of Birth: _____
Diagnosis: _____
Name of Medication: _____ Prescribed Dosage: _____
Frequency & Route of Administration: _____
Time(s) to be taken during camp hours: _____
Conditions under which medication is to be administered [for PRN (as needed) medications]:_____
Possible side effects or adverse reaction(s):_____
Prescriber's Name and Title (please print):_____
Prescriber's Signature: _____ Date: _____
Prescriber's Phone #: _____