Ardsley Day Camp
700 Ashford Avenue
Ardsley, NY 10502
Andy Beames, Director

Medical Release Form

AUTHORIZATION FOR ADMINSTRATION 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.

Guardian Signature: _____ Date: _____

Phone number: _____

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 number: _____