

Camp Address:
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Mailing Address:
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Camp W Medical Release Form

THIS FORM MUST BE COMPLETED AND RETURNED TO US IF YOU KNOW YOUR CHILD WILL NEED PRESCRIPTION OR OVER THE COUNTER MEDICATION DISPENSED AT CAMP. If not, save it for use during the summer if needed.

ALL medications (whether **PRESCRIPTION OR OVER THE COUNTER**) shall be brought to Camp by the parent/guardian or **BUS COUNSELOR** and shall be sent home when the medication is no longer needed or at the end of camp.

“Medication” shall include **ALL** medicines prescribed by a physician for the particular camper, including emergency medication in the event of bee stings, etc. and **ALL** over the counter medications. Before any medications may be administered to any camper during camp, we **REQUIRE** the **WRITTEN REQUEST** of the **PARENT/GUARDIAN** who shall give permission for such administration. In addition, we also **REQUIRE** the **WRITTEN ORDER** of **THE PHYSICIAN (EVEN for OVER THE COUNTER MEDICATION)** which shall include:

- A. The purpose of the medication
- B. The dosage, in original containers, specifically labeled
- C. The time at which or the special circumstances under which the medication shall be administered
- D. The length of time for which medication is to be taken
- E. The possible side effects of the medication

NAME _____ DOB _____ WEIGHT _____ AGE _____

DIAGNOSIS _____

MEDICATION/DOSAGE/TIME _____

POSSIBLE SIDE EFFECTS OF THE MEDICATION _____

The camp nurse has permission to administer the above medication as prescribed.

DOCTOR'S SIGNATURE _____

DATE _____ PHONE NUMBER _____

PARENT'S SIGNATURE _____ PHONE NUMBER _____

DATE _____