Park Shore Country Day Camp

450 Deer Park Road, Dix Hills, NY 11746-5205
Phone # (631) 499-8580 *Fax # (631) 499-6917

Self-Administration Medication Consent Form

ALL MEDICATIONS MUST BE PICKED UP BY PARENT/GUARDIAN THE CAMPERS LAST DAY OF CAMP

(No Medications will be allowed to go home with camper, regardless of age.)

Child's First and Last Name:	Date of Birth:	Telephone #:	Group/Division	Child's Known Allergies:

Authorized prescriber to complete

Licensed Authorized Prescriber's Name:	Licensed Authorized Prescriber's Telephone Number:	
Name of Medication (including strength if applicable):	Amount/Dosage to be Given:	Route of Administration:
Date to be Discontinued or Length of Time in Days to be Given:	Time(s) to be Given:	Refrigeration Required: Yes ○ No ○
Reason for Taking Medication (unless confidential by law):		
Possible Side Effects:	What Action to Take if Side Effects are Noted:	
Special Instructions: (include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies, or any pre-existing conditions. Also describe situations when medication should not be administered)		
For PRN medication only: Identify the Symptoms That Will Necessitate Administration of Medication:		

Medication Consent/Authorization

I, ________________________________ request that my son/daughter ___________________________ in the _________________
(Parent or Guardian's Name) (Child's Name) (Group)

self-administer the medication listed above.

I understand that he/she must bring the medication in its ***original*** prescription bottle or manufacturer's bottle with his/her name, the name of the medication and the dosage instructions. I understand that my son/daughter, and only my son/daughter will self-administer the medication as per his/her physician's orders. I attest that my son/daughter has demonstrated maturity, responsibility and capacity in self administering medication. I further attest that my son/daughter has demonstrated understanding of the indications and use of the prescribed medication (s) and that the medication (s) was prescribed solely for him/her.

Required Signatures

Licensed Authorized Prescriber's Name (please print)	Licensed Authorized Prescriber's Signature	Date
Parent or Legal Guardian's Name (please print)	Parent or Legal Guardian's Signature	Date
Camper's Name (please print)	(Camper's Signature)	Date
Name of Registered Nurse (please print) *(for office use only)*	Registered Nurse's Signature *(for office use only)*	Date Received from Parent *(for office use only)*