Park Shore Country Day Camp

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

Written Medication Consent Form

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

Authorized prescriber to complete:

Home Phone____________________
Cell Phone______________________

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, ________________________________ authorize Park Shore Country Day Camp's Licensed Registered Nurses to
(Parent/Legal Guardian)
administer the medication listed above to my child, ______________________ in Group ____________________.
(Child's Name)

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
Name of Registered Nurse (please print) (*for office use only*)	Registered Nurse Signature (*for office use only*)	Date Received from Parent (*for office use only*)