



Summer Day Camp Program

Medication Permission Form

Dear Parent/Guardian,

- Any camper or staff member needing to take/possess medication during the camp day must submit and have on file a completed "Medication Permission Form".
- Please use the "*Yorktown Parks & Recreation Summer Day Camp Medication Permission Form*". School forms are **not** valid. You **and** your child's prescribing Doctor must sign this form.
- There are two (2) forms – one (1) for Medications and Self Administration, and one (1) for Epi-Pen/Inhalers. Permission is needed for over the counter (OTC) medications that are prescribed by physician (ex. Benadryl). Please fill out the appropriate form.
- Please remember that all medication must be current and in its **original** package or prescription bottle.
- Please be sure to bring all medications and completed form on the **First** day your child attends camp. Campers will not be able to participate in camp without appropriate form on file. If needed, Camp Directors can withdraw campers from groups without medical forms.
- All medicine should be provided in the following manner:
 - Placed in a Ziploc bag in its original container
 - Include child's name and photograph
 - If your child is to carry his/her own medication, please make sure it is clearly labeled and easily accessible.
- Medication should be picked up on the campers last day of camp. After camp ends all medications can be picked up at the Parks & Recreation Office. All medicines not picked up will be discarded by September 1st.

Thank you. We look forward to a safe and healthy summer!

Sincerely,

Christopher Soi
Assistant Superintendent
Yorktown Parks & Recreation

Yorktown Parks & Recreation – Summer Day Camp Program

PERMISSION FOR MEDICATION & SELF ADMINISTRATION

As outlined in the Children's Camps Safety Plan Guide Section IV Part C- Medication must be self administered

NAME OF CAMPER _____ DATE OF BIRTH _____

Full address _____

Home Phone _____ Campsite Attending _____

Mother's Name _____ Day Time # _____ Cell _____

Father's Name _____ Day Time # _____ Cell _____

Emergency Contact _____ Phone # _____ Relation _____

MEDICAL INFORMATION

Physician Name _____ Physicians Phone _____

Health Insurance Carrier _____ Policy Number _____

MEDICATION	DOSAGE	WHEN TO ADMINISTER

All medication must be in original container with original prescription label and have current date of expiration.

Any Additional Information: _____

_____ I request that my child's prescription medication be securely stored in the camp office under the supervision of the camp staff. I certify that my child has been instructed and is capable of proper self administration of the medication.

_____ I request that my child be permitted to carry his/her prescribed medication at camp. I certify that my child has been instructed and is capable of proper self administration of the medication. My child has been instructed not to take the medication without medical designee present. I understand that if my child is using this medication unsafely, irresponsibly or fails to keep it out of reach from other campers, he/she will be taken to the camp office immediately and a call to the parent/guardian will be placed. I understand that the Town of Yorktown Parks & Recreation Department is not responsible for lost, stolen or improperly discharged medication.

I give permission to the onsite medical designee to seek emergency treatment at a hospital emergency room and to observe the above named camper while self-administering the above mentioned medication(s).

Signature of Parent/ Guardian

Printed Name of Parent/Guardian

Date

Signature of Child's Physician

Printed Name of Child's Physician

Date

Yorktown Parks & Recreation – Summer Day Camp Program

PERMISSION FOR PRESCRIPTION EPI-PEN and/or INHALER

NAME OF CAMPER _____ DATE OF BIRTH _____

Full address _____

Home Phone _____ Campsite Attending _____

Mother's Name _____ Day Time # _____ Cell _____

Father's Name _____ Day Time # _____ Cell _____

Emergency Contact _____ Phone # _____ Relation _____

MEDICAL INFORMATION

Physician Name _____ Physicians Phone _____

Health Insurance Carrier _____ Policy Number _____

TO BE COMPLETED BY PHYSICIAN or PRESCRIBED LICENSED HEALTH CARE PROVIDER

All medication must be in original container with original prescription label and have current date of expiration.

CHILD'S DIAGNOSIS _____

MEDICATION NAME _____ Dosage _____ Frequency _____

MEDICATION NAME _____ Dosage _____ Frequency _____

If medication is to be given "when needed," please circle indications

- | | | |
|---|-------------------------------|----------------------------|
| 1. Swelling of lips, tongue,
throat and or around the eyes | 4. Shortness of Breath | 7. Itchiness all over body |
| 2. Difficult swallowing | 5. Sever cough or wheezing | 8. Rash (Hives): |
| 3. Tightness in chest and or
difficulty breathing | 6. Itchiness around the mouth | 9. Other _____ |

Action to be taken? _____

How soon may it be repeated? _____

Additional information _____

_____ I request that my child's prescription epi-pen or inhaler be securely stored in the camp office under the supervision of the camp staff. I certify that my child has been instructed and is capable of proper self administration of the medication.

_____ I request that my child be permitted to carry his/her prescribed epi-pen or inhaler at camp. I certify that my child has been instructed and is capable of proper self administration of the medication. I understand that if my child is using this medication unsafely, irresponsibly or fails to keep it out of reach from other campers, he/she will be taken to the camp office immediately and a call to the parent/guardian will be placed. I understand that the Town of Yorktown Parks and Recreation is not responsible for lost, stolen or improperly discharged medication.

I give permission to the onsite medical designee to seek emergency treatment at a hospital emergency room and to observe the above named camper while self-administering the above mentioned medication(s).

Signature of Parent/ Guardian

Printed Name of Parent/Guardian

Date

Signature of Child's Physician

Printed Name of Child's Physician

Date