ALL medical records must be in our Recreation Office at least **ONE WEEK PRIOR** to your child's **start date.**
If ALL 3 FORMS are not received, your child will not be able to attend. No refunds. No exceptions.
We cannot guarantee follow up reminders as it is a parent responsibility to make sure all paperwork is received.

RECREATION OFFICE USE ONLY
OTHER MED FORMS RECEIVED → 1) Yearly Physical ____ 2) Immunization Record ____

MANDATORY PHYSICIAN'S ORDERS

This page to be filled out by a physician and returned to:
249 Duncan Rd, LaGrangeville, NY 12540 (845)724-5692 (FAX) tymorpark@unionvaleny.us

Child's **LAST Name**	Child's **FIRST Name**	___/___/___ Date of Birth	Date of Last Physical
Address	Town	State	Zip

Standard Over the Counter/PRN Medications (The following medications are available and will be administered at the discretion of the Health Director or designee, if approval is indicated by the child's Healthcare Provider.)

Drug Name	Route	Dosage	Indications	Physician's Order	Comments
Antibiotic Ointment	Topical	Per label instructions	Superficial cuts/ abrasions	Yes No	
Hydrocortisone Cream	Topical	Per label instructions	Allergic reactions (contact dermatitis, insect bites)	Yes No	
Calamine Lotion *(or generic)*	Topical	Per label instructions	Allergic reactions (hives, insect bite)	Yes No	
Saline Solution/Eye Wash	Topical	Per label instructions	Dust/sand in the eyes	Yes No	
Sting Relief	Topical	Per label instructions	Insect bite	Yes No	
Alcohol Wipes	Topical	Per label instructions	Superficial cuts/ abrasions	Yes No	

Prescription Medications: Includes Epi-Pens, Ritalin, etc. **CHILDREN MUST BE ABLE TO SELF-ADMINISTER.** Please complete with the patient's current regimen for both scheduled and PRN medications.

Drug Name	Route	Dosage & Schedule	Indications	Health Care Provider Order	Comments

Other Notes:_____

This form must be completed and signed by the child's physician.

This form must be filled out and signed for all children. Children taking any prescription medications while on-site **must be able to self-administer the medication** under the supervision of the Program Health Director/Designee.

Physician's Name:_____ Phone#:_____
Address:_____ License#:_____
Signature:_____ Date:_____