ALL medical records must be in our Recreation Office **PRIOR** to your child’s **start date. If ALL 3 FORMS are not received, your child will not be able to attend camp/program. 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) 724-5691 (PHONE) (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 |

 Program:  Traditional Camp  Kids Camp  CIT Program  TGTT Full Day  TGTT After-School

 Camp Session:  1  2  3  4

**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 camper’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** This includes Epi-Pens, Ritalin, etc. **CAMPER 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** | **Camper Health Care Provider Order** | **Comments** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

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

This form must be filled out and signed for all campers. Campers taking any prescription medications while at camp **must be able to self- administer the medication** under the supervision of the Camp Health Director/Designee.

On-Site Camp Health Directors are only permitted to dispense medications that are listed on this form by the child’s doctor.

Physician’s Name: Phone#: Address: License#: Signature: Date: