KENWAL DAY CAMP 100 DREXEL AVE MELVILLE, NY 11747 Phone # (631) 694-3399 *Fax # (631) 694-3841

ALL MEDICATIONS MUST BE PICKED UP BY PARENT/GUARDIAN ON CAMPER'S LAST DAY AT CAMP.

Written Medication Consent Form

Child's First and Last Name:	Date of Birth:	Child's Known Allergies:	COMMENTS

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 KENWAL Day Camp's Licensed Registered Nurses to
(Parent/Legal Guardian)
administer the medication listed above to my child, _____
(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***)