

**DEPARTMENT OF HUMAN RESOURCES
OFFICE OF CHILD CARE LICENSING AND REGULATION**

PHYSICIAN'S MEDICATION ORDER FORM

To be filled out by physician ordering medication and returned to parent. The parent must submit to Pine Valley Day Camp before medication is provided.

NOTE: A Certified Medical Technician will administer. If possible arrange time of dosage so that medication(s) will not have to be give while the child is in camp. **First dose must be administered at home.**

NAME OF PATIENT: _____

Drug Allergies: _____

The following medications must be given during camp hours:

CONDITION	MEDICATION	DOSAGE	TIME TO BE GIVEN (List specific time to administer.)	DATE OF FIRST DOSE
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

Administration (Specify if medication is to be given with water, milk, food, etc.) _____

For medications listed above, list all side effects, which should be observed by camp personnel.

1. _____
2. _____
3. _____

List any reasons for not giving medication at the prescribed time (vomiting, fever, drowsiness, convulsion, etc.): _____

This form must be kept current.

Whenever there is a change in the medication, the parents must have a new form completed by the physician. Pine Valley Day Camps' Camp Director or Camp Administrator can be reached at (410) 668-9888.

Physician's Signature: _____ Date: _____

Certified Nurse Practitioner: _____

Registered Physician Assistant: _____

Address: _____ Telephone: _____

TO PARENTS: Before the day camp, it's agents, employees or representatives, can administer any medication to your child, you are required to sign this agreement for which signifies your desire to have the camp staff CMT administer medication(s) as indicated, as well as your agreement to relieve the camp, its agents, employees or representatives of any responsibility for ill effects from administering of said prescribed medication as set forth herein.

I/We therefore authorize and request Pine Valley Swim and Tennis Club d/b/a Pine Valley Day Camp to the administration of the medication(s) prescribed by our physician, and in so doing relieve the camp, its agents, employees or representatives, of any responsibility for ill effects which may result from the administering of said prescribed medication.

Signature of Parent: _____ Date: _____

RETURN THIS FORM TO: Pine Valley Swim & Tennis Club 4638 White Marsh Road Baltimore, MD 21237 fax 410-663-3654