

**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 non-medical person will supervise the child who will self-administer medication(s).** 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. Send the medication to camp in the **original** or a **duplicate** box or bottle with the **current prescription label** on the container. (Upon request, pharmacists will label containers that can be used.) This includes inhalers, epi-pens and over-the-counter medications such as benadryl or tylenol.

**TO PARENTS:** Before the day camp, it's agents, employees or representatives, can provide access to any medication to your child, you are required to sign this agreement for which signifies your desire to have the staff supervise while your child self-administers medication(s), as well as your agreement to relieve the camp, its agents, employees or representatives of any responsibility for ill effects from supervision of the 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 supervise the self-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/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

NAME OF PATIENT: \_\_\_\_\_ D.O.B \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

The following medications must be given during camp hours:

CONDITION for which medication is being administered.	MEDICATION	DOSAGE	TIME TO BE GIVEN  (List specific time / circumstance to administer.)	DATE OF FIRST DOSE	Date of Discontinuation
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: \_\_\_\_\_