

## Medicine at Camp Form

If your child requires any medications (over-the-counter or prescription) to be taken and overseen at camp, please fill out the following table. This form also requires a doctor and parent/guardian signature. All medications must be in their original container when submitted to the Camp Director or Assistant Director.

Camper Name	
Camper DOB	
Camper Weight	
Parent Name	
Parent Contact Phone Number	

Drug	Route (orally, topically, etc....)	Dosage	Schedule and Indications	Comments/Side Effects	Prescription Number

**Physician/Doctor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*\*Doctor/Physician must attach a copy of the original Rx and complete the above.*

All medications must be in their original container when submitted to the Camp Director or Assistant Director. A copy of the prescription from the doctor must be attached to this form and on file at the Recreation Office (submit to [Imasset@twyny.org](mailto:Imasset@twyny.org)).

I hereby request that the staff of the Town of West Seneca Day Camp supervise my child taking the above medication as indicated. I understand the Town of West Seneca Day Camp staff cannot administer medicine to my child. I understand that the Town of West Seneca is not responsible for any lost, stolen, or misplaced medicine. I understand I must also submit to the West Seneca Recreation Office a valid prescription for any medicine over the counter or prescribed or my child will not be permitted to self-administer the medicine. I understand this form must be completed by myself and a doctor before my child can self-administer any medicine. I have read the Parent Handbook and understand all policies.

**Parent signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medicine Sign In (Completed By Camp Staff)** – Do not accept if above is not signed by both parent and a doctor, is not completed in full, does not contain the original RX and/or medicine is not in the original container.

Date In	Name of Medicine In	Name of Employee Who Signed In Medicine	Signature of Employee

### Parent Signing Medicine Out (Returned)

Date Returned	Name of Medicine Returned	Name of Parent Who Signed Out Medicine	Signature of Parent Who Signed Out Medicine

