

# CRESTWOOD COUNTRY DAY CAMP

313 Round Swamp Road Melville, NY 11747

Tel. (631) 692-6361 Fax. (631) 692-6987

www.crestwoodcountryday.com

## PARENT AND PRESCRIBERS AUTHORIZATION FOR ADMINISTRATION OF MEDICATION DURING SUMMER PROGRAM 2021

### A. TO BE COMPLETED BY THE PARENT OR GUARDIAN – parent or guardian signature required at the bottom of part A.

I request that my child \_\_\_\_\_ receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the Crestwood nurse or a designated Crestwood staff member will administer the medication and neither the Nurse nor Crestwood will be liable for any side effects and/or adverse reactions experienced by administering the medication as prescribed below.

**FOR EPIPEN ONLY:** I give permission for the Crestwood nurse or an epipen certified Crestwood staff member to administer an epipen to my child.

Signature (Parent or Guardian): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Date: \_\_\_\_\_

### B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER – Prescriber's signature required at the bottom of part B.

I request that my patient, as listed below, receive the following medication:

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Prescribed dosage, frequency and route of administration:

\_\_\_\_\_

Time to be taken during summer program hours: \_\_\_\_\_

Duration of treatment: \_\_\_\_\_

Possible side effects and adverse reactions (if any): \_\_\_\_\_

\_\_\_\_\_

Other recommendations: \_\_\_\_\_

\_\_\_\_\_

Name of licensed prescriber and title (please print): \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_