CRESTWOOD COUNTRY DAY CAMP

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PARENT AND PRESCRIBERS AUTHORIZATION FOR ADMINISTRATION OF MEDICATION DURING SUMMER PROGRAM 2024

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 administrating 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: _____