# Town of Babylon Day Camp

## Medication Form

**A. To be completed by the parent/guardian:**

I request that my child _____ receive the medication as prescribed by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy.

**B. To be completed by physician:**

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

Camper's Name _____ DOB _____

Diagnosis: _____

List Medication(s)

| MEDICATION | DOSAGE | FREQUENCY/TIME TO BE TAKEN | ROUTE OF ADMINISTRATION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Possible Side Effects and Adverse Reactions (if any):_____

_____

**PLEASE CHECK ONE:**

☐ I deem this child to be self directed.

☐ I deem this child to be non-self directed and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the parent.

Physician's Signature _____ Date _____

Physician's Stamp: Phone# _____