Challenge Camp
Carole B Berman, Executive Director
2225 Westchester Avenue, Rye, NY 10580
914-779-6024 p   914793-2685 f
Www.challengecamps.com   carole@challengecamps.com

CAMP POLICY WILL BE STRICTLY FOLLOWED REGARDING ANY MEDICATION NEEDED TO BE ADMINISTERED TO CAMPERS AT ANY TIME DURING CHALLENGE CAMP

Dear Parents:

Please call our medical staff with any questions that you have.

Parents and camper's physician MUST complete and sign/date the attached medical form regarding dispensing of medication.

All medication MUST be brought to the Challenge Camp Health Office by the PARENT in the original container from the pharmacy which filled the prescription.

ALL CAMP MEDICATION POLICIES apply to all dispensing of medication, even the request for over the counter products like aspirin or non aspirin pain reliever.

All medication will be kept in the camp Health Office under the supervision of our Challenge Health Staff.

Thank you for your cooperation.

Brenda Guy, R.N.
Berenice Miller, R.N.

Health Directors

CHALLENGE CAMP

Medication to be dispensed at camp by camp staff

Individualized Orders for__________________________ DOB______________ Weight_____________

For all PRESCRIPTION and Non PRESCRIPTION medication, you must bring the dose needed for the camp session in its ORIGINAL CONTAINER, and complete this medical form so that it can be administered to your child. A DOCTOR'S SIGNATURE IS REQUIRED for both prescription and non prescription medications. Campers cannot medicate themselves, only Challenge Camp staff nurses can dispense medication.

Medications (prescription & over the counter) to be administered during camp hours.

DOCTOR'S SIGNATURE REQUIRED

Medication_________________________________ **Dosage**__________________ **Route**_________

Time of day medication given__________________ For how long (duration)______________________

Purpose of medication____

Possible side effects/Comments____

____

____

Doctor's Signature________________________________ Phone_________________ Date________

Doctor's Address____ License #____________________

Parent/Guardian Signature____ Date___________

Medication_________________________________ **Dosage**__________________ **Route**_________

Time of day medication given__________________ For how long (duration)______________________

Purpose of medication____

Possible side effects/Comments____

____

____

Doctor's Signature________________________________ Phone_________________ Date________

Doctor's Address____ License #____________________

Parent/Guardian Signature____ Date___________