Physician Authorization For Supervised Child Self-Administered Medication Form

As permitted by the Putnam County Board of Health, the Putnam Valley Summer Program will supervise child's self-administration of physician prescribed medication. Our Health and Safety Director/Camp Nurse will supervise the child's self-administered medication, once the following conditions have been met:

• Medication is transported to Summer Program, and delivered to our Health and Safety Director/Camp Nurse (not child's counselor) by an adult only (not the child).
• All medication (including over-the-counter) must be brought in its **original container and labeled with:**

- o Complete name of patient
- o Date prescription was filled (not applicable to over-the-counter medication)
- o Expiration date
- o Specific directions for use
- o Name and address of dispensing pharmacy (not applicable to over-the-counter medication)
- o Name and phone number of prescribing health care provider

I hereby give permission for my child _____ to receive the medication listed below, as prescribed by my child's Personal Physician. I understand that this medication will be self-administered, under the supervision of our Health and Safety Director/Camp Nurse.

Medication: _____
Dosage: _____
Special Instructions: _____
Self-Administered Time: _____
Side Effects: _____

Summer Program Staff should notify the following physician _____ at the following phone number __ __ __ - __ __ __ - __ __ __ __, if the following side effects occur: _____

_____

_____ _____
Signature of Parent/Guardian Signature of Physician
(This signature is authorization for both parents/guardians)

_____ _____
Name of Parent/Guardian (Print) Name of Physician (Print)
Date:_____ Date:_____

Form can be faxed to (845)-306-2114 or Emailed: TCortina@putnamvalley.com