

WESTCHESTER SUMMER DAY
856 Orienta Avenue Mamaroneck, NY 10543
Administration of Medication Release Form

Dear Parents:

At times, during the summer day, children may experience aches and pains from a cold, have seasonal allergies, and at times may develop a fever. We would like to be prepared for these situations. The Westchester County Board of Health requires **your child's physicians' permission to administer such medications as Tylenol, Antihistamine-decongestant, Ibuprofen or Epi-pen**. If you would like our nurse to administer such medications to your child, we require that this form be completed and returned to: **Westchester Summer Day 856 Orienta Avenue Mamaroneck, NY 10543**

TO BE COMPLETED BY THE PHYSICIAN FOR EVERY MEDICATION (prescription and over the counter)

Child's name _____ Diagnosis _____

Medication _____ Dose _____ Frequency _____

Duration _____

If PRN, signs and symptoms for administering medication _____

Possible side effects _____

Restrictions (what and how long?) _____

Print M.D. Name, Address, Tel. No. _____

NYS Reg. # _____

Date _____ M.D. signature _____

Prescription medication must be in a PRESCRIPTION BOTTLE with a proper pharmacist's label attached. The label must list the student's name, medication and physician. Over the counter medication is to be labeled with the student's name.

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby request that the Westchester Summer Day nurse (or Director's designee) administer medication as prescribed by my child's physician.

Child's name _____ Date of Birth ____/____/____ Grade _____

Parent/Guardian Daytime Tel. # _____

I hereby release Westchester Summer Day and the employees of Westchester Summer Day from any and all liability arising from the administration of this medication.

Date ____/____/____ Parent/Guardian signature _____

SELF MEDICATION RELEASE FORM

(for asthmatics carrying an inhaler on campus, or other specific medication)

This section must be completed in addition to the above, for those children who request permission to carry their own medication on campus.

Date ____/____/____ Child's name: _____ has been instructed in the proper use of the following medication procedures: _____

We, (Physician's signature) _____ and

(Parent's signature) _____ request that

(Child's name) _____ be permitted to carry the medication on his/her person. He/ she has been instructed in and understands the purpose and appropriate method and frequency of use.