1221 Pond Street, Franklin, MA 02038 Telephone 508 533 8882

Dear Parent/Guardian:

We would like to inform you of the policies that have been put into place to ensure the health and safety of the children needing medicines during the camp day.

Our camp requires that the following forms must be on file with your child's health form before we can give any medicine at camp.

1. Signed consent by the parent or guardian to give the medicine.
   Please complete the consent from and return it to the camp nurse.

2. Signed medication order.
   The written medication order form should be taken to your child's licensed prescriber (your child's physician) for completion and returned to the camp nurse with the medication.

Medicines should be delivered to the camp in a pharmacy or manufacturer-labeled container by you or a responsible adult whom you designate. Please ask your pharmacy to provide separate bottles for camp and home.

When you child needs a medicine to be given during the camp day, please act quickly to follow these policies so we may begin to give the medicine as soon as possible.

Thank you for your help.

Sincerely yours,

Gail Lembo, Director

P.S. If your child will not be taking medication at camp, please disregard this letter.

Franklin Country Day Camp
Authorization For Medication

The following section is to be completed by the Parent or Guardian

Child's name: _____ _____ _____
Last First Sex Date of Birth

_____ (____)_____
Physician's Name Address Telephone

I request that my child be assisted in taking the medicine(s) described below at camp by authorized persons as authorized by me and my physician.

_____ _____ (____)_____ (____)_____
Date Parent/Guardian Signature Home Phone Emergency Phone

The following section is to be completed by the PHYSICIAN

Diagnosis for which medication is given:_____

Name of Medication:_____

Form:_____

Dose:_____

If medication is to be given at camp, at what time?_____

If medication is to be given "WHEN NEEDED" describe indications:_____
_____

How soon can it be repeated?_____

List significant side effects:_____

Length of time this treatment is recommended:_____

Other Information: _____
_____

_____ _____
Date **PHYSICIAN'S SIGNATURE**