Hillel Day CAMP

MEDICATION NOTIFICATION

Dear Parent/Guardian,
If, at any time, it is necessary for your child to receive medication during camp hours, the medication will be administered, only if the following conditions are met:

1. The attached Medication Permission Request Form must be completed for all medications. **This includes over-the-counter medication and prescription medication**. The **physician** must include the time, dosage and any side effects of the medication.
2. The above is accompanied by a signed request from the **parent/guardian** giving permission for the designated school authority to administer the medication. The parents signature and daytime phone number should be written on the attached Medication Permission Request Form
3. **Over-the-counter medications must be received in the original, unopened container.** Prescription medication must be in the **original prescription bottle**, labeled by a registered pharmacist and stating the dosage of the prescribed medication and time the medication should be administered. (All pharmacies will make up a small bottle and label it for school.)
4. **An adult should bring all medications to school**, unless specific arrangements have been made with the health office.
5. A new medication request form must be submitted if there is any change in medication or dosage.
6. A new medication request form must be submitted at the beginning of each school year.

REMINDER: **The Nurse Practice Act prohibits registered nurses from giving any medication, even Tylenol, without a written doctor's order.** No medication is kept in the health office other than medication sent in by parents specifically for their child. Children returning to camp after a contagious illness or those children sent home due to illnesses of a contagious nature, must be readmitted to camp with a doctor's note stating that is safe for them to return. Under no circumstances will Hillel deviate from these directives issued by the Department of Health.

To Be Completed by Physician

Medication	Dosages per pill (mg)	Number of pills per dose	Total Dosage	Times A.M. P.M.	Reason/ Diagnosis

________________________ Date

________________________ Signature of Physician

________________________ Physician's telephone #

M.D. office stamp

________________________ Physician's name printed

To be Completed by Parent

I, ________________________, give permission for my child________________________
To receive the above medication as directed.
Date__________________ Parent's Signature__________________________________
Home phone #____________________ cell phone #________________________
Beeper#__________________________ work #____________________________