TOWN OF PAWLING RECREATION DEPARTMENT
LAKESIDE PARK
2 LAKESIDE DRIVE
845-855-1131

ALL medical records must be in our Recreation Office at least **TWO WEEKS PRIOR** to your child's **start date.**
If ALL 3 FORMS are not received, your child will not be able to attend camp. No refunds. No exceptions.
We cannot guarantee follow up reminders as it is a parent responsibility to make sure all paperwork is received.

RECREATION OFFICE USE ONLY
OTHER MED FORMS RECEIVED → 1) Current Physical _____ 2) Immunization Record _____

_____   _____   ___/___/___   _____
Camper **LAST Name**   Camper **FIRST Name**   Date of Birth   Date of Last Physical

_____   _____   _____
Parent/Guardian Full Name   Parent/Guardian Cell Phone   Parent/Guardian Email

Camp Program: _____ Traditional   _____ Leadership Training Camp   _____ Counselor Training Camp

Session(s):   ____ 1 ____ 2 ____ 3 ____ 4

Standard Over the Counter Medications

The following medications are available and can be administered at camp by the Health Director or designee,
Parents/Guardian must initial for each over the counter medicine.

Drug Name	Route	Dosage	Indications	Guardian Approval	Comments Guardian's Initial
Antibiotic Ointment	Topical	Per label instructions	Superficial cuts/ abrasions	Yes No	
Hydrocortisone Cream	Topical	Per label instructions	Allergic reactions (contact dermatitis, insect bites)	Yes No	
Calamine Lotion	Topical	Per label instructions	Allergic reactions (hives, insect bite)	Yes No	
Saline Solution (Eyes)	Topical	Per label instructions	Dust/sand in the eyes	Yes No	
Sting Relief	Topical	Per label instructions	Insect bite	Yes No	
Alcohol Wipes	Topical	Per label instructions	Superficial cuts/abrasions	Yes No	

Prescription Medications

This includes Epi-Pens, Inhalers, etc. **CAMPER MUST BE ABLE TO SELF-ADMINISTER.**

On-Site Camp Health Directors are only permitted to dispense medications that are listed on this form by the child's physician

Drug Name	Route	Dosage & Schedule	Indications	Camper Health Care Provider Order	Comments

PHYSICIAN MUST SIGN BELOW AND FORM MUST BE RETURNED TO PAWLING RECREATION

Physician's Name:_____   Phone#:_____
Address:_____   License#:_____
Signature:_____   Date:_____