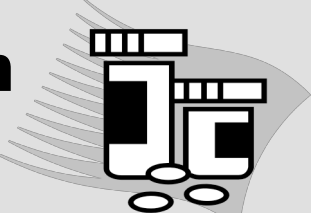


Mail back
this form by
June 1

**Medication
Dosage &
Frequency** (1 Form Per Camper)




**AMERICA'S
CAMP**

Please Mail To:
3 New King Street
White Plains, NY 10604

To be filled out only by a physician if child takes Daily or PRN medication.

Camper's Name: _____

Physician's Name (print): _____

Physician's Signature: _____ Date: _____

My child does not require daily or PRN medication:
Parent's Signature: _____

DAILY

	Medication(s)	Dosage	Notes
Breakfast			
Lunch			
Dinner			
Bedtime			

PRN or "As Needed" Medications:

PRN Medication	Dosage	Symptoms