



## Future Stars at SUNY Old Westbury –

### 'Epi-Pen' / Medication Standing Order Form 2026

**Important (1of2):** This form must be completed and signed by parent/guardian AND Physician before the camper may begin camp, if attending with an 'Epi-Pen' and/or Medications.

Upload to your [CampInTouch Account](#) OR Scan to [oldwestbury@fscamps.com](mailto:oldwestbury@fscamps.com).

'Epi-Pen' and/or Medications should be placed in a clearly labeled zip lock bag with a copy of this form, and can be handed to camp medical/office staff prior to the start of camp, or on Monday(s) during arrival.

Camper's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Cell/Work # \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Cell/Work # \_\_\_\_\_

#### **Dear Parent/Guardian**

Efforts should be made to administer medications at home, prior to your child's camp day. However, if your physician feels that it is necessary for your child to take medication during camp hours, our camp medical staff will properly store/secure the medication and monitor when usage occurs.

**MEDICATION(S) MUST BE IN THE ORIGINAL CONTAINER OR PRESCRIPTION BOTTLE WITH DOSAGE LABEL.**

**'EPI-PENS' MUST BE IN THE ORIGINAL BOX WITH PRESCRIPTION/DOSAGE LABEL**

Campers are at no time allowed to carry medication, of any kind, throughout the camp day (aside from inhalers).

The physician must approve any carry permission. Campers must not take medication without official written directives from the physician, and without supervision of our camp medical staff.

#### **Parent/Guardian Authorization**

I hereby request that Future Stars Summer Camps medical staff supervise my child as he/she administers the medication provided, as prescribed by the physician.

*\*Epi-Pens are NOT expected to be self-administered, if needed.*

Parent/Guardian Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Important (2of2):** This section of the form must be completed – and signed/stamped - by your physician

#### **Physician Instructions**

Camper Name \_\_\_\_\_

Reason for 'Epi-Pen' (Allergic To:) \_\_\_\_\_

Medication & Dosage (I) \_\_\_\_\_

Medication & Dosage (II) \_\_\_\_\_

Physician Signature / Stamp \_\_\_\_\_

Date \_\_\_\_\_