Wediko
CHILDREN'S SERVICES

Dear Parent/Guardian,

Enclosed you will find the Health forms that must be completed before your child can begin the Wediko Summer Program. We understand the process is time consuming; please understand that it is critical that we have this information to insure the highest standard of health and safety for your child this summer.

Enclosed, please find:

1. **Physician's Exam Report and Immunization Records (REQUIRED)** – Wediko must have a record of a physical, done within the past year prior to attendance and signed by the student's physician, updated immunization records, and the most recent TB test results. The enclosed form is provided for your physician's convenience; some physicians may prefer to use their own forms.

2. **Medication Administration Permit / Physician's Orders (REQUIRED)** – Different than a prescription, this form allows us to administer your child's medication. Any prescription medications that your child needs to take at Wediko must be listed on this form with current dosages and directions. This form must be signed by a doctor.

3. **Over-the-Counter (OTC) Medication Administration Permit (REQUIRED)**
   - Included in this packet is a form which lists all of the OTC medications that we will have stocked. Please check off those that your child may need, keeping in mind that when away from home in a new environment they may experience symptoms they haven't in their home environment.
   - These OTC medications will be administered only after assessment by a licensed nurse and will be administered according to manufacturer's guidelines (usually based on weight and/or age). Your child's physician may also give specific dosing instructions if preferred.
   - We will NOT administer OTC medications without written consent from from both the Parent/Guardian and Physician.

4. **Health History Form (REQUIRED)** – Information on this form will help Wediko staff identify appropriate health care for your child.

Medical/Emergency Treatment Permission (REQUIRED) – In the event of an emergency, this form allows Wediko staff to seek emergency medical treatment for your child. Wediko will make every attempt to contact parents/guardians.

Established 1934
www.wediko.org

Boston Headquarters
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Boston, MA 02118
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Fax: (617) 292-9272

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5. **Issues of Adolescence: Authorization for Medical Treatment and Consultation (REQUIRED for ages 11+)** – As students enter adolescence, concerns regarding substances and sexual behavior may require consultation and/or treament. This form is required for all students aged 11 and older.

6. **Allergy Action Plan** – Please complete this form if a significant allergy is noted on the Health History form.
   - If your child has a life-threatening allergy, please complete the enclosed Food Allergy and Anaphylaxis Emergency Care Plan, sign it and have it signed by the child's physician.
   - For children who have a known allergy which may require the use of an Epipen, it is a REQUIREMENT that parents/guardians supply two (2) Epipens which will not expire before August 24, 2016. One Epipen will remain with the Nursing Staff and the other will remain with cabin staff trained in Epipen administration.
   - Whenever it is appropriate, your child's physician should sign consent for self-administration of the Epipen. In that case, your child would be allowed to carry an Epipen on their person. In the event that it was needed, it could be self-administered or administered by a staff person.

7. **Asthma Action Plan –** Please complete this form if asthma is noted on the Health History form.
   - For children who have been prescribed the use of a "rescue" inhaler to be used to treat asthma symptoms, it is a REQUIREMENT that parents/guardians supply two (2) inhalers which will not expire before August 24, 2016. One inhaler will remain with the Nursing Staff and the other will remain with cabin staff trained in inhaler administration.

8. **Lenox Village Pharmacy Information & Enrollment Instructions (REQUIRED)** –Wediko partners with Lenox Village Integrative Pharmacy to provide pharmacy services for students during the Summer Program. Village Pharmacy will send weekly supplies of the student's medications directly to Wediko in pre-packaged doses, to be administered by Wediko's Nursing Staff. Enrollment in Village Pharmacy is required this summer. There is no additional cost to parents to use Village Pharmacy. Like a regular pharmacy, parents are still responsible for co-pays and non-covered items, but any charges associated with the program are taken care of by Wediko. Some of the many benefits include:
   - Greatly reduced time spent in the registration process on Arrival Day;
   - Eliminates the need to send medication to Wediko throughout the summer;
   - Reduced errors in pouring multiple medication dosages;
   - Student will return home at the end of the summer with an approximately two (2) week supply of medication;

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- Once original paperwork is completed, your work is done. You can relax knowing that your student's medication is being delivered directly to Wediko and administered by licensed nurses;
- Wediko Nursing Staff will have more time available for health-related issues other than medication administration, such as first aid, health counseling, and health education programs.

Please note that parents must provide Village Pharmacy with a hard copy of the prescription. Please see the enclosed information for enrollment instructions.

Please complete and return the required forms to the Wediko Boston Office. If you have indicated that your child has a specific medical need, a licensed nurse will contact you to create a health care plan. If you have any questions or concerns about the Medical Forms or our partnership with Village Pharmacy, please contact us at (617)292-9200.

I speak for all the nurses when I say that we look forward to meeting you and your child on July 5th!

Sincerely,

Jennifer Franz, RN
Summer Program Nurse Manager

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CHILDREN'S SERVICES

PHYSICIAN'S EXAM REPORT

Child's name: ______________________________

DOB: ____________________ Age: ______________ Sex: M F

Allergies (including medications and insect stings): ______________________

____

Health history (please check all that apply):

Chicken Pox	____	Asthma	____	Seizures	____
Joint/Bone problems	____	Ear infections	____	Strep throat	____
Headaches	____	Operations	____	Bed wetting	____
Skin conditions	____	Hospitalizations	____	Other	____

Please explain any health concerns checked above: ______________________

____

Current medical diagnosis: ______________________

Current medications:

Medication Dosage and time Reason for

____

____

____

Immunizations:

DTP, Td, DT						
Polio						
MMR						
Hep B						
Varivax						
HIB						
Other						

Last TB test: ____________________ Results: ____________________

Height: ______________ Weight: ______________ BP: ______________

☐ Capable of full participation in camp activities including gymnastics and athletics

☐ Limited participation as explained: ______________________

Physician's signature: ____________________ Date: ______________

Physician's name: ____________________ Phone #: ______________

Address: ______________________________

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Wediko
CHILDREN'S SERVICES

PHYSICIAN SIGNATURE NEEDED

MEDICATION ADMINISTRATION PERMIT

Prescription medication requires the **prescribing physician's signature**, as well as the other information below and a parent's or **guardian's authorization**.

Please also note:

- All medications must be in original, labeled containers.
- Copies of prescriptions are not acceptable substitues.

Physician's Order

Child's name: ______________________________ DOB: ________________

Medication   Dosage and time   Reason for

____

____

____

____

Physician's signature: ________________________ Date: ____________

Physician's name: ____

Address: ____

Phone #: ________________________ Fax #: ________________________

Parent's or Guardian's Authorization

I hereby request and give my permission for a designated member of the Wediko staff to assist my child, ____, in taking medication prescribed by Dr. __________________________________ and release said person from responsibility for any adverse effects from the medication.

I give Wediko staff permission to contact the above health care provider to discuss medications or treatments of my child, ___________________________, or to obtain or share medical records as deemed pertinent to my child's care.

Parent / Guardian's signature: ___________________________ Date: ______________

Wediko
CHILDREN'S SERVICES

PHYSICIAN SIGNATURE NEEDED

OVER-THE-COUNTER MEDICATION ORDER

TO BE COMPLETED BY LICENSED PRESCRIBER AND AUTHORIZED WITH A PARENT/GUARDIAN SIGNATURE FOR ANY OVER-THE-COUNTER MEDICATION TO BE DISPENSED

Name of Student: ______________________________ DOB: ________________

Address ____
(Street) (City/Town)

LICENSED PRESCRIBER: Please complete this form for above named student.

Name of Licensed Prescriber ______________________ Title ________________

Business Telephone Number ________________ FAX Number________________

I give permission for a Wediko Nurse or personnel designated by the Wediko Nurse to give the following over-the-counter medications as deemed necessary and according to the manufacturer's instructions. These medications will by administered only after assessment by a licensed nurse.

ORAL ADMINISTRATION

- ❑ Acetaminophen (Tylenol)
- ❑ Anesthetic throat spray
- ❑ Antihistamine (Benadryl/Diphenhydramine)
- ❑ Anti-diarrhea (Immodium/Kaopectate)
- ❑ Calcium antacid tablets (Tums)
- ❑ Decongestant (Sudafed/pseudophedrine)
- ❑ Ibuprofen (Advil/Motrin)
- ❑ Menthol cough drops
- ❑ Midol
- ❑ Oragel

TOPICAL ADMINISTRATION

- ❑ Aloe gel
- ❑ Antibiotic ointments
- ❑ Athlete's Foot medication
- ❑ Anti-itch (Benadryl gel/Calamine)
- ❑ Bactine First Aid spray
- ❑ Hydrocortisone cream
- ❑ Muscle rub (menthol)
- ❑ Saline solution

❑ Other over-the counter medication not listed above that will be provided by parent:
____
____

LICENSED PRESCRIBER AUTHORIZATION

Licensed Prescriber Signature ________________ Printed Name ________________

Date of Order ______________________ Discontinuation Date ____________

PARENT / GUARDIAN AUTHORIZATION

Parent/Guardian Signature ________________ Printed Name ________________

Relationship to Student ________________ Date ________________

Wediko
CHILDREN'S SERVICES

Medical/Emergency Treatment Permission

Child's Name: ______________________________ DOB: ______________ Gender: M / F

Child's Medical Insurance Co. ____

Subscriber's Name: ____________________ Relationship to Subscriber: ______________

Policy # ____________________________ Group # ______________________________

I hereby authorize Wediko Summer Program Staff to consent to whatever medical care that my child may require during my absence. In the even of serious illness or injury, or the need for surgery or other major procedure that is not emergent, the temporary responsible party will use all reasonable efforts to contact me. Failure to successfully contact me, however, should not delay or prevent any licensed provider from providing such treatment as may be advised in my child's best interest.

Name of Child ____

Signature of Parent/
Legal Guardian ____

Printed Name of Parent/
Legal Guardian ____

Date ___________________________

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Issues of Adolescence: Authorization for Medical Consultation

For adolescents, possible medical treatment emergencies include use of illegal drugs and sexual behavior. The tightly structured environment and high staff ratio provides excellent prevention against such problems, but we want to be straightforward in sharing that we can offer no 100% guarantees. Although Wediko is committed to using all its resources to help with such issues, it is also understood by both the parents and the adolescent that such behavior provides grounds for dismissal from the Summer Program. Finally, given the sensitive and personal nature of both drug-related and sexual behavior problems, such issues will be kept confidential between Wediko staff and the individual adolescent unless clear physical risks or suspension from the Summer Program are indicated. As the parent/guardian of this adolescent, I have read this additional section; and I hereby give permission to seek medical consultation and help as deemed appropriate by the Wediko supervisory staff.

Name of child ____

Signature of Parent/

Legal Guardian ____

Printed Name of Parent/

Legal Guardian ____

Date ______________________

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HEALTH HISTORY

Student Name: ________________________________ Date of Birth:_____________

Information on this form is gathered to assist Wediko staff in identifying appropriate health care.

GENERAL HEALTH QUESTIONS	YES	NO	If YES, please explain:
Medication Allergies			EPIPEN? YES ☐ NO ☐
Peanut/Nut Allergy			EPIPEN? YES ☐ NO ☐
Food Allergies			EPIPEN? YES ☐ NO ☐
Lactose Intolerance			
Environmental/ Seasonal Allergies			EPIPEN? YES ☐ NO ☐
Bee Sting/Insect Bite Allergy			EPIPEN? YES ☐ NO ☐
Hospitalization or Surgery			
Asthma			Inhaler? YES ☐ NO ☐
Diabetes			
Seizure Disorder			
Heart Problems			
Infectious Diseases			
Bleeding/Clotting Disorders			
Bowel/Bladder Problems			
Skin Problems			
Frequent Ear Infections			Tubes? YES ☐ NO ☐
Syndrome/Disorder/Other Conditions			
Recent Injury or Illness			Date: _______ Explain:
Frequent Headaches/Head Injury			
Describe past medical treatment, if any:			

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FARE

Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: ______________________ D.O.B.: __________

PLACE STUDENT'S PICTURE HERE

Allergy to: ______________________

Weight: __________ lbs. **Asthma:** [ ] Yes (higher risk for a severe reaction) [ ] No

For a suspected or active food allergy reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] **If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms.**

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting or severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. **Use Epinephrine.**

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

[ ] **If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.**

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

MEDICATIONS/DOSES

Epinephrine Brand: ______________________

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: ______________________

Antihistamine Dose: ______________________

Other (e.g., inhaler-bronchodilator if asthmatic): ______________________

____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

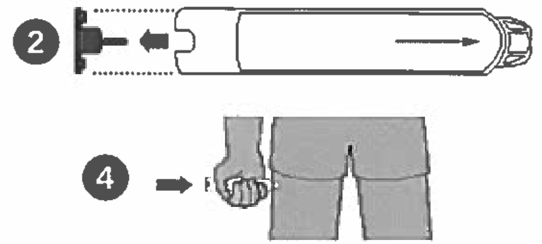
FARE

Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

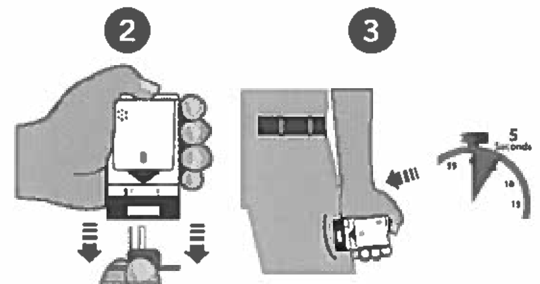
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat student before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: ____________________

DOCTOR: ____________________ PHONE: __________

PARENT/GUARDIAN: ____________________ PHONE: __________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: ____________________

PHONE: ____________________

NAME/RELATIONSHIP: ____________________

PHONE: ____________________

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

Asthma Action Plan

For: ____________ Doctor: ____________ Date: ____________

Doctor's Phone Number ____________ Hospital/Emergency Department Phone Number ____________

GREEN ZONE

Doing Well

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,

Peak flow: more than ____________ (80 percent or more of my best peak flow)

My best peak flow is ____________

Take these long-term control medicines each day (include an anti-inflammatory).

Medicine	How much to take	When to take it

Before exercise ¬ ____________ ¬ 2 or ¬ 4 puffs ____________ 5 minutes before exercise

YELLOW ZONE

Asthma Is Getting Worse

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

Peak flow: ______ to ______ (50 to 79 percent of my best peak flow)

First: **Add: quick-relief medicine—and keep taking your GREEN ZONE medicine.**

____________ (short-acting beta$_2$-agonist) ¬ 2 or ¬ 4 puffs, every 20 minutes for up to 1 hour ¬ Nebulizer, once

Second: **If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:**

¬ Continue monitoring to be sure you stay in the green zone.

-Or-

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:

¬ Take: ____________ (short-acting beta$_2$-agonist) ¬ 2 or ¬ 4 puffs or ¬ Nebulizer

¬ Add: ____________ (oral steroid) mg per day For ______ (3-10) days

¬ Call the doctor ¬ before/ ¬ within ______ hours after taking the oral steroid.

RED ZONE

Medical Alert!

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

-Or-

Peak flow: less than ____________ (50 percent of my best peak flow)

Take this medicine:

¬ ____________ (short-acting beta$_2$-agonist) ¬ 4 or ¬ 6 puffs or ¬ Nebulizer

¬ ____________ (oral steroid) mg

Then call your doctor NOW. Go to the hospital or call an ambulance if:

- You are still in the red zone after 15 minutes AND
- You have not reached your doctor.

DANGER SIGNS

- **Trouble walking and talking due to shortness of breath**
- **Lips or fingernails are blue**

- **Take ¬ 4 or ¬ 6 puffs of your quick-relief medicine AND**
- **Go to the hospital or call for an ambulance ____________ (phone) NOW!**

See the reverse side for things you can do to avoid your asthma triggers.

How To Control Things That Make Your Asthma Worse

This guide suggests things you can do to avoid your asthma triggers. Put a check next to the triggers that you know make your asthma worse and ask your doctor to help you find out if you have other triggers as well. Then decide with your doctor what steps you will take.

Allergens

❒ **Animal Dander**

Some people are allergic to the flakes of skin or dried saliva from animals with fur or feathers.

The best thing to do:

- Keep furred or feathered pets out of your home.

If you can't keep the pet outdoors, then:

- Keep the pet out of your bedroom and other sleeping areas at all times, and keep the door closed.
- Remove carpets and furniture covered with cloth from your home. If that is not possible, keep the pet away from fabric-covered furniture and carpets.

❒ **Dust Mites**

Many people with asthma are allergic to dust mites. Dust mites are tiny bugs that are found in every home—in mattresses, pillows, carpets, upholstered furniture, bedcovers, clothes, stuffed toys, and fabric or other fabric-covered items.

Things that can help:

- Encase your mattress in a special dust-proof cover.
- Encase your pillow in a special dust-proof cover or wash the pillow each week in hot water. Water must be hotter than 130° F to kill the mites. Cold or warm water used with detergent and bleach can also be effective.
- Wash the sheets and blankets on your bed each week in hot water.
- Reduce indoor humidity to below 60 percent (ideally between 30–50 percent). Dehumidifiers or central air conditioners can do this.
- Try not to sleep or lie on cloth-covered cushions.
- Remove carpets from your bedroom and those laid on concrete, if you can.
- Keep stuffed toys out of the bed or wash the toys weekly in hot water or cooler water with detergent and bleach.

❒ **Cockroaches**

Many people with asthma are allergic to the dried droppings and remains of cockroaches.

The best thing to do:

- Keep food and garbage in closed containers. Never leave food out.
- Use poison baits, powders, gels, or paste (for example, boric acid). You can also use traps.
- If a spray is used to kill roaches, stay out of the room until the odor goes away.

❒ **Indoor Mold**

- Fix leaky faucets, pipes, or other sources of water that have mold around them.
- Clean moldy surfaces with a cleaner that has bleach in it.

❒ **Pollen and Outdoor Mold**

What to do during your allergy season (when pollen or mold spore counts are high):

- Try to keep your windows closed.
- Stay indoors with windows closed from late morning to afternoon, if you can. Pollen and some mold spore counts are highest at that time.
- Ask your doctor whether you need to take or increase anti-inflammatory medicine before your allergy season starts.

Irritants

❒ **Tobacco Smoke**

- If you smoke, ask your doctor for ways to help you quit. Ask family members to quit smoking, too.
- Do not allow smoking in your home or car.

❒ **Smoke, Strong Odors, and Sprays**

- If possible, do not use a wood-burning stove, kerosene heater, or fireplace.
- Try to stay away from strong odors and sprays, such as perfume, talcum powder, hair spray, and paints.

Other things that bring on asthma symptoms in some people include:

❒ **Vacuum Cleaning**

- Try to get someone else to vacuum for you once or twice a week, if you can. Stay out of rooms while they are being vacuumed and for a short while afterward.
- If you vacuum, use a dust mask (from a hardware store), a double-layered or microfilter vacuum cleaner bag, or a vacuum cleaner with a HEPA filter.

❒ **Other Things That Can Make Asthma Worse**

- Sulfites in foods and beverages: Do not drink beer or wine or eat dried fruit, processed potatoes, or shrimp if they cause asthma symptoms.
- Cold air: Cover your nose and mouth with a scarf on cold or windy days.
- Other medicines: Tell your doctor about all the medicines you take. Include cold medicines, aspirin, vitamins and other supplements, and nonselective beta-blockers (including those in eye drops).

U.S. Department of Health and Human Services
National Institutes of Health

National Heart
Lung and Blood Institute

For More Information, go to: www.nhlbi.nih.gov

NIH Publication No. 07-5251
April 2007

Dear Parent(s),

Lenox Village Integrative Pharmacy, Inc ("LVIP") is honored to partner with the Wediko Summer Program to provide pharmacy services for your child. LVIP is an independent pharmacy which has been family owned and operated for over 25 years. Our unique business model offers you and your child a traditional retail pharmacy, a non-sterile compounding pharmacy, a large selection of pharmaceutical grade vitamins and supplements, and an institutional fulfillment pharmacy with customized medication packaging.

LVIP will dispense your child's medications in pre-packaged individual medication dosages ("Healthy Living Pre-Paks"). This system utilizes a state-of-the-art computerized packaging machine that assures quality control and produces individual packets solely for your child. Each packet shows your child's name, the date it is to be given and the time to be administered, thereby eliminating mistakes or forgotten medications. The nursing staff no longer has to open individual vials and count pills.

Healthy Living Pre-Paks offer:

- Sterile Packaging
- High Tech/Higher Standards
- Safety
- Improved Compliance
- Reduced Risk

LVIP will also work with your insurance company and bill them directly for your child's medications. You only pay for your insurance co-pay, non-covered items and over-the-counter items. LVIP accepts almost all insurance plans, Medicaid and Medicare.

LVIP's pharmacists oversee the entire process from start to finish-reviewing your child's prescription, computer programming, and machine loading. They also perform post-production audits on every medication that leaves the pharmacy.

We are happy to speak with you at any anytime to answer questions or more fully describe our pharmacy. We can be reached either by telephone (413-637-4700) or by email at abrowne@LvipRx.com or jmartragono@LvipRx.com. We look forward to working with you and filling your child's medication needs.

Sincerely yours,

Anne Browne Joseph Martragono

ENROLLMENT INSTRUCTIONS

Our convenient and secure online registration system is a quick and easy way to order your child's prescribed medications and nutritionals for the duration of his/her stay at the Wediko Summer Program.

To get started you will need to:

1. Visit LVIP online at www.lviprx.com/prepaks to fill out the **online "2016 Camp Pharmacy Form."** Please fill in all requested information. If you have limited internet access and would like a hard copy of the Form, please contact the Wediko Boston office.

2. When you have completed the form, click the "submit" button to generate a two-page PDF file with a unique bar-code in the upper right hand corner of each page. Print a copy of this file and bring it to your child's physician, who will then issue the prescriptions necessary for the duration of your child's stay at the Wediko Summer Program.

3. Send the completed Camp Pharmacy printout (with the barcodes) along with your child's prescriptions to:
   Lenox Village Integrative Pharmacy
   5 Walker Street
   Lenox, MA 01240
   Attention: Colleen, Billing

If you have any other questions, or should you wish to speak with a pharmacist, please contact Jeff Brown at (413) 637-4700 x109, or via email at jbrown@LvipRx.com.

At LVIP we are committed to you and your family's total health and we look forward to serving you.

Dear Physician,

Your patient will be attending the Wediko Summer Program from July 5, 2016 through August 18, 2016 and will be using the Lenox Village Integrative Pharmacy, Inc. ("LVIP") to prepackage their medications. The medication in tablet or capsule form will be dispensed in compliance dose packaging for safer dispensing. Each packet will be labeled with the patient's name, medication(s) name, RX number, date, and administrative time. All medications will be sent to the Wediko Summer Program. Due to most insurance regulations, all medications will be dispensed in 30 day increments. Please see separate instructions for Schedule II Medications below.

Parents must have original prescriptions to cover the entire treatment period. We must receive the **original prescriptions no later than June 15, 2016.** To facilitate an orderly start to your patient's stay, we ask you to please follow these guidelines:

Non-Controlled Medications - Please write for 30 day supplies with one (1) refill. Any medication not used at the Wediko Summer Program will be sent home.

Controlled Substances/Schedule II Medications - Please write separate prescriptions for each 30 day supply that will be needed, up to a total of two (2). All prescriptions for controlled substances must be dated as of, and signed on, the day when issued. However, due to the amendment in the DEA regulation for writing Schedule II medications (Docket No DEA-278F, effective 12/19/07), you may provide your patient with multiple prescriptions to be filled sequentially for the same Schedule II medication. These prescriptions must provide written instructions on each separate prescription indicating the earliest date on which a pharmacy may fill each prescription.

For Controlled Substance/Schedule II Medications, where multiple 30 day prescriptions are used, please write the following prohibition on the prescription, "Do not fill before (insert date 30 days after the preceding prescription, i.e. Do not fill before February 1, 2015)".

Please include your DEA and NPI numbers on all prescriptions.

If you have any questions, please contact Jeff Brown, RPh, at (413) 637-4700 x109 or by email at jbrown@LvipRx.com.

Thank you!