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Dear Parents:

In our ongoing commitment to ensure the safety of campers and staff who will be taking medications, vitamins, or supplements daily while at camp, Remedies Pharmacy will be providing medications and vitamins in prepackaged form for the upcoming summer. This is for all medications/vitamin in pill form (not creams or liquid medication).

PARTICIPATION IS MANDATORY FOR ALL CAMPERS AND STAFF MEMBERS UNDER THE AGE OF 18, WHO TAKE MEDICATIONS, VITAMINS, OR SUPPLEMENTS ON A DAILY BASIS.

- All orders for medication must be placed directly through Remedies Pharmacy. Please write on the prescription 'Camp Romimu', along with the camper's/staff member's name.
- The only cost is the cost of your medication or copay. There is no service fee.
- The form and doctor prescriptions must be submitted by June 1st.
- This program is mandatory. Campers who do not have their medications, vitamins, or supplements packaged by Remedies Pharmacy will be subject to a $50 fee to repackage their medications.
- Remedies Pharmacy accepts NYS Medicaid, and all major insurances.
- If your child takes a medication that requires a new prescription every time it is filled, please have your doctor postdate prescriptions or leave date field blank when you submit them. For electronic prescriptions please have your doctor change the effective date on the prescription to June 23, 2022, for first trip campers and July 21, 2022 for second trip campers.

Please review and complete the attached documents immediately. Please send directly to Remedies Pharmacy.

Thank you in advance for your cooperation.

Deadline to Submit Prescriptions is June 1st

Remedies Pharmacy

711 Bedford Avenue
Brooklyn, NY 11206
karinapharmmed@gmail.com
Tel: 718-855-0214 Fax 718-855-0358

Romimu Camper/Staff Member: Last Name **First Name** **Date of Birth**

Address: Street **City** **State** **Zip** **Parent E-mail Address**

Parent/Guardian Last Name **First Name** **Home Phone** **Summer Contact Number**

1st Session / 2nd Session / Full Summer

Cell Number **Trip attending Camp Romimu (please circle)** **Allergies**

Insurance Card
Front of Card

If you have more than one insurance, please include copies of all cards

Insurance Card
Back of Card

If you have more than one insurance, please include copies of all cards

Name of Medication	**Strength**	**Quantity/Time of Day:** (Please circle and fill in)
		wake-up breakfast lunch dinner bedtime other: _____ **# of tabs:**_____/_____/_____/_____/_____/_____
		wake-up breakfast lunch dinner bedtime other: _____ **# of tabs:**_____/_____/_____/_____/_____/_____
		wake-up breakfast lunch dinner bedtime other: _____ **# of tabs:**_____/_____/_____/_____/_____/_____
		wake-up breakfast lunch dinner bedtime other: _____ **# of tabs:**_____/_____/_____/_____/_____/_____
		wake-up breakfast lunch dinner bedtime other: _____ **# of tabs:**_____/_____/_____/_____/_____/_____

(if there are more medication than lines provided please attach a second page)

PAYMENT: VISA AMERICAN EXPRESS OR MASTERCARD:

I hereby authorize Remedies Pharmacy to charge my credit card all co-payments associated with the medication that I order. I agree to pay for any items that are not covered by my insurance plan.

Card Holder Name/Signature Card Number Expiration Date / CVV Code

Please Mail, Fax, or Email forms to the address listed above.
Please attach all prescriptions not submitted by your doctor