בס״ד

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 or vitamins in pill form, whether it is prescription or over the counter medication. This does not refer to liquid medication, inhalers, growth hormone shots, creams or ointments.

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

• 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.
• 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 additional service fee when complying with the given guidelines.
• All forms and prescriptions (for second half) must be submitted by July 22, 2024.
• Over-The-Counter (OTC) drugs (i.e. Claritin, Mel-O-Chew, any vitamin) must also be prepackaged by Remedies Pharmacy. All new orders must be placed directly through the pharmacy, not the OTC department.
• Remedies Pharmacy accepts NYS Medicaid, and all major insurances.
• The form on page two is for informational purposes. New prescriptions for all medications must be sent to Remedies pharmacy either electronically or by postal mail.
• Please keep in mind that your child may have different Hebrew and English names—fill out both on page two.
• If you have requested prescriptions from your child’s doctor but did not receive any phone call from Remedies Pharmacy to confirm, please call the pharmacy.
• As camp time approaches, please avoid filling any 30 or 90 day prescriptions at your local pharmacy. The local pharmacy should be able to provide a partial fill to carry through until the camp start date.
• If your child takes a controlled substance such as Onfi, Adderall, Vyvanse, etc., please do not ask your doctor to post-date electronic prescriptions. If post-dating is required, request these prescriptions be sent via regular postal
mail.
• If your child is on a very expensive brand-name medication (e.g. Quillchew ER), please call Remedies Pharmacy to
determine if the medication is stocked and to confirm if it can be ordered for your child.
• Please send the completed second page directly to Remedies Pharmacy via our fax 718-855-0358 or email to karinapharmmed@gmail.com

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

July / August / 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