PHYSICIAN INSTRUCTION LETTER

Caregiver, please complete.

PATIENT NAME:	DATE OF BIRTH:	
CAMP ATTENDING:	CAMP START DATE:	CAMP END DATE

Dear Healthcare Provider,

Your patient will be attending a camp that employs a Medication Therapy Management System provided by Campers Pharmacy. All medication in pill form will be dispensed in dose packaging (unit or multi-dose depending on state law). The pre-packaged medication will be sent directly from our pharmacy to the camp. We request you follow these guidelines when submitting prescriptions to us.

CONTROLLED SUBSTANCES:

- Please write prescriptions for 30-day supplies.
- If Camper will be staying longer than 30 days, Camper will need 2 separate prescriptions written sequentially.
- The body of the prescription must provide written acknowledgement that indicates the earliest date the prescription can be filled.
    - For example, if the first prescription is dated 05/01/2022, the second should be written acknowledging the earliest fill date using the phrase "Do Not Fill Before ____" based on your state regulations. Do Not Fill date should be at least 2 weeks prior to the start of the camp session.
- Do not postdate prescriptions.
- Prescriptions for controlled substances must be e-prescribed or written on an original prescription pad and mailed to Campers Pharmacy. Faxed prescriptions for controlled medications will not be accepted.

OTHER PRESCRIPTION MEDICATIONS, VITAMINS, & SUPPLEMENTS:

- Prescriptions should be written for 30-day supply with enough refills to cover the camp stay.
- Epi-pens and other injectables will not be filled by Campers Pharmacy
- Inhalers, and allergy medication should include an action plan for symptomatic use
- Prescriptions for non-controlled medication may be faxed, mailed, or sent via E-Script

OTC MEDICATIONS, VITAMINS, & SUPPLEMENTS

- All over the counter medications, vitamins, and supplements require a completed OTC form signed by the physician.
- We strongly encourage liquid and gummy medications be exchanged for oral disintegrating tables or chewable

Prescriptions should be submitted as soon as possible to ensure continuity of care.
Please be sure all prescriptions include your License number, DEA number and NPI number.

E-PRESCRIBING	**MAIL**	**FAX**	**VERBAL**
Valley Pharmacy NABP:NCPDP: 3115474 NPI: 1083644819	Valley Pharmacy 107 Rt. 10 Succasunna NJ 07876	973.584.7266	973.584.5555 TOLL FREE: 866.218.1834

Questions? Please email us at info@camperspharmacy.com
or call 973-584-5555 / 973-850-3360 or 866-218-1834

Thank you for helping make this a happy camp season for your patient!

Campers Pharmacy is a service provided by Valley Pharmacy

OVER THE COUNTER (OTC) MEDICATION, VITAMIN & SUPPLEMENT FORM

- This form is to be used only for OTC medications, vitamins, and/or supplements
- Please complete a separate form for each camper
- Caregiver, complete form; In order to be valid, Physician must sign, date, and supply provider number
- We strongly recommend any medication in liquid or gummy form be exchanged for another formulation.
- Leftover medication will be returned with your camper.

Camper's Full Name: ___________________________________ Date of Birth: ___/___/___

Camp Attending: ___________________________________ Session: ___________________________________ Start Date: __________ End Date: _____________

OTC MEDICATION/ VITAMIN/SUPPLEMENT	**DOSAGE/ STRENGTH**	**DAYS SUPPLY NEEDED** CIRCLE ONE	**DIRECTIONS**	**FORMULATION** PILL, TABLET, CAPSULE, ORAL DISINTEGRATING TABLET, CHEWABLE, DROPS, POWDER, OINTMENT, CREAM	**TIMING*** CIRCLE ALL THAT APPLY **If no timing is selected, we will follow established guidelines*	**GENERIC OR BRAND** CIRCLE ONE *If Brand, please list below*
		30 | 60			BREAKFAST | LUNCH | DINNER | BEDTIME | AS NEEDED | OTHER___________________	GENERIC | BRAND
		30 | 60			BREAKFAST | LUNCH | DINNER | BEDTIME | AS NEEDED | OTHER___________________	GENERIC | BRAND
		30 | 60			BREAKFAST | LUNCH | DINNER | BEDTIME | AS NEEDED | OTHER___________________	GENERIC | BRAND
		30 | 60			BREAKFAST | LUNCH | DINNER | BEDTIME | AS NEEDED | OTHER___________________	GENERIC | BRAND
		30 | 60			BREAKFAST | LUNCH | DINNER | BEDTIME | AS NEEDED | OTHER___________________	GENERIC | BRAND

By signing below, you are confirming all medications on this form are accurate

Physician Name: ___________________________________ NPI: ___________________________________

Physician Signature: ___________________________________ Date: ___________________________________

Parent Name: ___________________________________

Parent Signature: ___________________________________ Date: ___________________________________

EMAIL COMPLETED FORM TO INFO@CAMPERSPHARMACY.COM AT LEAST 30 DAYS PRIOR TO THE START OF YOUR CAMP SESSION.
INCLUDE CAMPERS NAME, CAMP NAME & CAMP SESSION IN SUBJECT.