Campers Name: _____ Camp Week(s) _____

AUTHORIZATION FOR USE OF OVER-THE-COUNTER MEDICATIONS

To be completed by physician

Check off below the over-the-counter medications that this patient is able to take.

- ❑ Robitussin Cough Drops
- ❑ Calamine Lotion
- ❑ Bacitracin Ointment
- ❑ Junior Strength Tylenol
- ❑ Tylenol Gelcaps - Extra strength
- ❑ Imodium A-D caplets
- ❑ Contact Caplets - Non-drowsy
- ❑ Robitussin DM
- ❑ Benadryl Allergy Tablets
- ❑ Benadryl Antihistamine Liquid
- ❑ Advil
- ❑ Motrin
- ❑ Sugar Free Cherry Cough Suppressant Drops
- ❑ Hydrocortisone Cream USP 1%
- ❑ Anbesol
- ❑ Pepto-Bismol Chewable Tablets and Liquid
- ❑ Sudafed Nasal Decongestant - Max. Strength
- ❑ Ex-lax regular strength
- ❑ Antacids
  - ❑ Maalox
  - ❑ Milk of Magnesium
  - ❑ Mylanta
  - ❑ Generic Liquid Antacid
  - ❑ Tums - Regular strength
- ❑ Generic Ibuprophen

Other recommendations:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Physician Name (please print): _____

Physician Signature: _____

Telephone No.:_____ Date: _____

Office Hours: _____

CAMP SUNRISE/SNOWBALL PARENTAL & PHYSICIAN'S AUTHORIZATION FOR ADMINISTERING PRESCRIPTION MEDICINES

INSTRUCTIONS:

1. **ALL** prescription medications **MUST** be brought to Camp in the original container dispensed from the pharmacy with proper labeling.
2. The medication MUST be brought to Camp accompanied by **A COPY OF THIS FORM**. Be sure you have included all of the following information: a) camper's name, b) name of drug, c) dosage and frequency, d) doctor's name, address and telephone number, e) possible side effects, f) condition being treated and g) doctor's signature.
   IF WE ARE NOT IN RECEIPT OF THESE FORMS AT CAMP REGISTRATION, WE WILL NOT BE ABLE TO ACCOMMODATE YOUR CAMPER. NO REFUNDS WILL BE AWARDED IN THIS SITUATION.

AUTHORIZATION FOR DISPENSING PRESCRIPTION MEDICATION

To be completed by Parent/Guardian

I request that _____, age _____ receive the medication as prescribed below by his/her physician. This medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the Camp Nurse or other designated person will administer the medication. My physician has also completed the over-the-counter medications authorization for this camper. I understand that unless otherwise indicated, the Camp Nurse will administer over-the-counter medications as needed.

_____ _____ _____

Parent/Guardian Signature | Telephone Number | Date

TO BE COMPLETED BY PHYSICIAN

I request that my patient, as listed below, receive the following medication:

Patient Name: _____ Age: _____

Diagnosis: _____

NAME OF MEDICATION	PRESCRIBED DOSAGE & MEANS OF ADMINISTERING	TIME TO BE ADMINISTERED	EXPECTED DURATION OF TREATMENT	POSSIBLE SIDE EFFECTS & ADVERSE REACTIONS

Physician Name (please print): _____

Physician Signature: _____

Telephone No.:_____ Date: _____

Office Hours: _____

PLEASE REPRODUCE IF YOU NEED TO LIST ADDITIONAL INFORMATION