

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.

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

Physician Name (please print): _____
Physician Signature: _____
Telephone No.: _____ Date: _____
Office Hours: _____