CREATIVE SUMMER 2022
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OVER-THE-COUNTER MEDICATION ADMINISTRATION AUTHORIZATION FORM

This form must be completed fully and on file in the Infirmary in order for a camper to have formulary list OTC medication (see list below) provided by the camp during a camp day. A new and completed *OTC Medication Authorization Form* is required annually.

In order for non-prescription medication, not on the formulary list below, to be dispensed it must be provided by the parent/guarding in the unopened original container with the label intact. A *Medication Administration Authorization Form*, completed and signed by both a physician and a parent, must accompany the medication.

The Camp Nurse may call the prescriber, as allowed by HIPAA, if a question arises about the camper and/or the camper's medication(s).

PRESCRIBER'S AUTHORIZATION

CHILD'S NAME	☐ MALE ☐ FEMALE	DATE OF BIRTH ____/____/_____ Month Day Year
PARENT/GUARDIAN NAME		PHONE

PRESCRIBERS – Please indicate medications camper may receive

Formulary List Medications	✓ Check here if permitted	Dose (if blank, as directed by package)	PRN for what symptoms	Relevant Side Effects/ Special Instructions
Acetaminophen Tablets 325 mg each	☐		Pain, Fever <100	
Acetaminophen Pediatric Liquid	☐		Pain, Fever <100	
Ibuprofen Tablets 200 mg each	☐		Pain, Fever <100, inflammation	
Ibuprofen Pediatric Liquid	☐		Pain, Fever <100, inflammation	
Diphenhydramine HCl Tablets 25 mg each	☐		Itching, sneezing, congestion, allergic response	
Diphenhydramine HCl Liquid	☐		Itching, sneezing, congestion, allergic response	
Tums >12 year old	☐	2 tablets	Acid indigestion	
Aluminum Hydroxide/Magnesium Hydroxide Tablets	☐	2 tablets	Mild nausea, mild diarrhea	
Hydrocortisone 1% cream	☐	Topical	Itching	
Triple Antibiotic Cream	☐	Topical	Cuts, scrapes	
Medicaine Swabs	☐	Topical	Insect bites, itching	
Mentholyptic Cough Lozenges	☐	1 lozenge	Coughing, sore throat	

12. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 14b below unless more restrictive dates are specified in 12a and 12b. This authorization is ***NOT TO EXCEED 1 YEAR***.	12a. FROM ____/____/_____ Month Day Year	12b. TO ____/____/_____ Month Day Year

13. PRESCRIBER'S NAME/TITLE			This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIPCODE	

14a. PRESCRIBER'S SIGNATURE ***(Parent/guardian cannot sign here)***	14b. DATE

II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication as prescribed by the above prescriber. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

15a. PARENT/GUARDIAN SIGNATURE	15b. DATE

15c. HOME PHONE #	15d. CELL PHONE #	15e. WORK PHONE #