

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/guardian 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

1. CHILD'S NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	2. DATE OF BIRTH ____ / ____ / ____ <small style="text-align: center;">Month Day Year</small>
3. PARENT/GUARDIAN NAME		4. 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	
Mentholypic Cough Lozenges		1 lozenge	Coughing, sore throat	

5. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 8b below unless more restrictive dates are specified in 6a and 6b. This authorization is NOT TO EXCEED 1 YEAR.	6a. FROM ____ / ____ / ____ <small style="text-align: center;">Month Day Year</small>	6b. TO ____ / ____ / ____ <small style="text-align: center;">Month Day Year</small>
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7. PRESCRIBER'S NAME/TITLE	This space may be used for the Prescriber's Address Stamp	
TELEPHONE		
FAX		
ADDRESS		
CITY	STATE	ZIPCODE

8a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only - cannot be digital)	8b. DATE
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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.

9a. PARENT/GUARDIAN SIGNATURE	9b. DATE
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9c. HOME PHONE #	9d. CELL PHONE #	9e. WORK PHONE #
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