Name _____ Date of Birth_____

Form 2
Medication Form

Over-the-Counter Medications The following medications will be available at camp, but will only be administered by the camp health director, **if approved here by the participant's healthcare provider**. No medication will be dispensed at camp to anyone under the age of 18 without the signed approval of the participant's healthcare provider.

Drug Name	Dosage	Schedule and Indications	Approval	Comments:
Bismuth Subsalicylate (Pepto Bismol)	Per Label Instructions	PRN for diarrhea	Yes No	
Calcium Carbonate (Tums)	Per Label Instructions	PRN for Indigestion	Yes No	
Dipenhydramine (Benadryl)	Per Label Instructions	PRN for minor allergic reaction	Yes No	
Kaolin (Kaopectate)	Per Label Instructions	PRN for diarrhea	Yes No	
Loratidine (Claritin)	Per Label Instructions	PRN for minor allergic reaction	Yes No	
Acetaminophen (Tylenol)	Per Label Instructions	PRN for pain or fever	Yes No	
Ibuprofen (Advil)	Per Label Instructions	PRN for pain or fever	Yes No	
Pseudoephedrine (Sudafed)	Per Label Instructions	PRN for congestion	Yes No	
Cough drops	Per Label Instructions	PRN for minor throat discomfort	Yes No	
Calamine Lotion	Per Label Instructions	PRN for skin irritation and insect bites	Yes No	
Cortisone Ointment	Per Label Instructions	PRN for minor pain/discomfort	Yes No	
Triple Antibiotic Ointment	Per Label Instructions	PRN for minor skin irritation	Yes No	

Over-the-Counter Medications brought from home If there are over-the-counter medications not listed above that the participant will be bringing from home which they need to take at camp, please list them here. **All medications must be brought in original packaging with instruction label intact and labeled with camper's complete name.**

Camp Health Director use only

Drug Name	Dosage	Schedule and Indications	Comments:	In	Out

Prescription Medications **All prescription medications must be brought in original packaging with pharmacist's label.**

Camp Health Director use only

Drug Name	Route	Dosage	Schedule and Indications	Comments:	In	Out

Allergies to Medications List any medications to which the participant is allergic.

_____

_____

I certify that the above information is complete and accurate to the best of my knowledge. Further, I give the camp medical personnel permission to administer the medications as indicated on this form.

_____ _____

Signature of Healthcare Practitioner Date