CHAMBERS WESLEYAN CAMP-MEDICATION FORM

Please return by faxing form to 607-936-9444 OR emailing to: chamberscampnurse@gmail.com OR bring to camp registration

1) Camper Name ___________________________

2) Parent/Guardian signature ___________________________

***Over-the-counter medications listed below are stocked in the CSM Health Center and provided as needed *if* you have a physician's signature.**

Drug Name	Provider Order	Drug Name	Provider Order
Tylenol/Acetaminophen(discomfort/fever)	YES NO	Visine (regular & allergy) for eye irritation	YES NO
Advil/Ibuprofren (discomfort/fever)	YES NO	Calamine Lotion (skin irritation)	YES NO
Benadryl (allergies)	YES NO	Tums (heartburn/stomach upset)	YES NO
Cortizone Cream (topical) for skin irritation	YES NO	Pepto-Bismol (nausea)	YES NO
Saline Solution (nasal wash or eye wash)	YES NO	Cough Drops (throat irritation or cough)	YES NO

5) Camper's Current Prescription and Over-The-Counter Medications

***Medications include, but are not limited to: prescription medications, over the counter medications, inhalers, ointments, prescription face wash, prescription mouthwash/rinse, homeopathic remedies and vitamins.**
All medications, properly labeled, in the ORIGINAL CONTAINER and with a valid expiration date are required to be turned into the camp medical staff upon registration. Medications are distributed at wake up, meal times, bedtimes and between activities as needed.

Drug Name	Dosage	Schedule am/pm/meals/bed/as needed	Comments (with food etc)

****Emergency medications are available and with your authorization, the Health Director/Medical Staff can act according to their best judgment where medical or surgical treatment is required.****

Is your camper aware of what medications he/or she will be taking while at camp? ____YES ____NO

3) PHYSICIAN AUTHORIZATION REQUIRED: **Required to administer all Over-the-Counter medications**
Signature:____________________________
Date:________________________
Address:______________________________
____
Phone No: _____________________________

OR: ***(please check)***
NO:______ I do not wish for my child to receive any Over-the-Counter medications. ***This will be automatically defaulted without a physician's signature.*** **__________________________________(*Parental Signature required*)**