Chambers Camp & Retreat Center - Medication Form

Last Name:_________________ First Name:___________________ DOB:_____________

Child's Doctor must fill out this section:

Oral Agents	Dosage	Indication	Approved	Comments
Benadryl		Allergic Reaction/hay fever every six hours as needed for 24 hours	Yes No	
Ibuprofen		Headache, pain control	Yes No	
Imodium		Diarrhea, as needed for watery stool	Yes No	
Pepto Bismol		Upset stomach	Yes No	
Robitussin		Colds, every six hours as needed	Yes No	
Tylenol		Fever, headache, pain control, toothache every 4 hours as needed	Yes No	
Topical Agents				
Triple Antibiotic Ointment		Wound care	Yes No	
Desenex Powder		Athletes foot	Yes No	
Gold Bond Powder		Jock itch	Yes No	

Insect Repellent & Sunscreen ***Brought to camp by camper, non-aerosol only***	Per Label instruction	My son/daughter may apply or, if requested to a leader, may have applied, insect repellent and sunscreen that he/she has brought to camp.	Yes No	Parent Signature required here

*Specifications for Prescription Medications and the required signatures are to be indicated on the back of this page.

Camper's Current Prescription and Over-the-Counter Medications

***Medications include, but are not limited to: prescription medications, over the counter medications, ointments, prescription face wash, homeopathic remedies, and vitamins.**

All medications, properly labeled, in the <u>ORIGINAL CONTAINER</u>, and with a valid expiration date are required to be turned into the camp medical staff upon registration. Medications are distributed are wake up, meal times, bedtimes, and between activities as needed.

Drug Name	Dosage	Schedule AM/PM/Meals/bed/as needed	Comments (with food etc)

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

This form Must be sign by the parent/guardian as well as the Camper's Health Care Provider in order for the above over-the-counter medications* to be received, as per New York State Law.

Health Care Provider____________________________________ Phone:____________________

Address/City/State/Zip____________________________________ License #__________________

Signature: ____ Date:__________

Parent/Guardian Approval: I request that my son/daughter receive the above over-the counter medications as indicated by my child's Health Care Provider (required for under the age of 18)as needed.

Parent/Guardian____________________________________ Phone:____________________

Address/City/State/Zip____________________________________ Relationship: __________________

Signature: ____ Date:__________