

DRUG AUTHORIZATION FOR SUMMER 2008

Name of Camper _____

The following over the counter medications or generic equivalent are available in the camp health office. They may be dispensed at the discretion of the camp nurse in age/weight appropriate doses only as needed.

Tylenol	Neosporin Ointment	Robitussin cough med.	Tums/Antacid	Benadryl
Advil/Motrin	Hydrocortisone cream	Throat Lozenger/cough drops	Pepto-Bismol	Caladryl/Calamine lotion

I herewith give my permission for the camp nurse to administer the above listed medication(s) to my child as needed.

Signature of Parent or Guardian

Date _____

If you do not want your child to receive any (or all) of the above listed medication, please indicate that in the space provided and sign

Signature _____ Date _____

Every prescription drug and any over the counter drug to be taken by the camper during his/her time at Aldersgate must be listed on this form. ALL DRUGS MUST COME IN THEIR ORIGINAL CONTAINERS. The signature of the prescribing physician must appear next to each prescription drug, the signature of the parent next to each over the counter drug.

Name of Drug	Condition for which it is being taken	Daily Administration (must agree with container)	Drug Cautions	Signature Printed name of sign.
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

In the event of out of camp trips, I herewith give my permission for the director or the counselor of my child's camp to administer prescribed medication to my child according to my physicians directions as indicated on the label of the prescribed medicine and/or for the director or counselor of my child's camp to administer over the counter medication according to my directions as indicated on this Drug Authorization form.

Parent or Guardian signature