Doctor's Approval for Medication Form 2025

Check only <u>one</u> of the boxes below:

☐ I, the parent or guardian, **<u>decline</u>** access to medications under all situations for the child named below:

Child: _____ **Parent/Guardian Signature:** _____ **Date:** _____

Declining access to medications means that the child will not have access to PRN or prescription medications on camp, but will be taken to medical services off camp if necessary.

☐ I, the parent or guardian, will ensure completion of the box below in its entirety (<u>including a doctor's signature</u>):

This box should be completed and signed by a physician.
Note: a physician's signature is <u>required</u> for any medication, vitamins, or supplements.

Doctor's Name _____ Doctor's Phone _____

Child Name: _____ Birth Date: _____ / _____ / _____

Camp may supply the standard over-the-counter (PRN) medications listed below. These will be administered at the discretion of the Camp Health Director if the physician indicates approval. Indicate which meds can be dispensed to this child by camp health director.

Drug Name	Doctor Order	Dosage	Schedule	Comments
Acetaminophen (Tylenol)	YES NO			
Burn Ointment	YES NO			
Calamine Lotion	YES NO			
Calcium Antacid (Rolaids, Tums)	YES NO			
Diphenhydramine (Benadryl)	YES NO			
External Analgesic (Ben Gay, Icy Hot)	YES NO			
Guifenison (Robitussin)	YES NO			
Hydrocortisone 1%	YES NO			
Ibuprofen (Advil)	YES NO			
Loperamide (Immodium)	YES NO			
Lozenges (Halls, Chloraseptic)	YES NO			
Sting Eze for Insect Bites and Stings	YES NO			
Triple Antibiotic Ointment	YES NO			

Indicate current instructions for scheduled medications, vitamins, and supplements. Use an additional page if needed. All medication must be in original containers and will be secured in the camp medical center.

Prescription Drug Name	Dosage	Route	Schedule	Comments

Vitamins/Supplements	Dosage	Route	Schedule	Comments

Is the child following a medically prescribed meal plan or diet? ☐ YES ☐ NO *(If yes, attach written description.)*

Include any additional relevant recommendations/information such as operations or serious injuries with dates, disability, or chronic illness. Attach additional pages as necessary.

_____

_____

_____

Doctor's Signature: _____ **Date:** _____