



**PECONIC DUNES 4-H CAMP**  
**Medication Authorization Form**

***This form MUST be completed for ALL Campers.***  
***If you do not want the camp nurse to administer any medications to your child,***  
***check the box at the end of this form and sign.***

***A health care professional's signature is required if your child is to receive any medication.***

Camper Name \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Phone Number \_\_\_\_\_

The following non-prescription (OTC) medications\* are stocked in the Camp Health Center and are used as needed to manage illness and injury. All OTC medications will be administered per instructions on the label.

**Medical personnel: Cross out any medications a camper *CANNOT* take.**

For fever/pain	For cold/allergies	For stomach distress	For topical treatment
Acetaminophen (Tylenol) Ibuprofen (Advil)	Diphenhydramine (Benadryl) Pseudoephedrine (Sudafed) Loratadine (Claritin) Cetirizine (Zyrtec) Dextromethorphan (Cough syrup) Guaifenesin (Cough syrup)	Calcium antacid (Tums)	Antibiotic ointment Burn ointment Aloe Anti-itch cream (Calagel, Calamine, etc) Poison ivy wash (Tecnu) Hydrocortisone cream Anti-sting/itch spray Chloraseptic spray Swim Ear (ear drops) Antifungal spray/powder
<i>*Name brands are only used for identification purposes. Generic equivalents may be used.</i>			

***This camper will take the following medication(s) while at camp. Include EPI Pens & Rescue Inhalers if applicable.***

Name of medication	Dosage	Schedule	Specific instructions: take with food, must be refrigerated, self-carry (rescue inhaler only).

***If there are any changes to medications, a new form will be required prior to camper attending.***

*I have reviewed and verified the information on this form and provide the above standing orders for medication administration. I understand that the camp health designee/RN will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.*

**Health care provider signature** \_\_\_\_\_ Date \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION**

I request that designated camp personnel to administer the medications above as authorized. I certify that I have legal authority to consent to medical treatment for the camper named above, including the administration of medication at camp as detailed above. I understand that all medications must be given to the camp nurse upon arrival and picked up by an adult at the end of the camper's session, or it will be discarded. I authorize the camp nurse or health designee to communicate with the health care provider as allowed by HIPAA.

**NO, I do not authorize any medications, including over the counter (OTC), to be given to my child while at camp.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_