Youth Camp Medication Authorization Form

Please Note: In compliance with NYS law, this form **must** be completed for your child to receive **any and all medications,** including prescriptions.

Please have the camper's doctor, physician's assistant or nurse practitioner review this form and indicate agreement /disagreement with each listed over-the-counter medication and sign at the bottom.

Blank spaces are provided for any prescription medications the camper will take at camp.

Our health and safety staff cannot administer medications without the appropriate signature.

All over-the-counter medications must be in the original bottles, marked with the name and dose of medication. Prescription medications bottles must be clearly labelled with camper's name, dose, routine of administration, frequency, and provider's name.

Name of Camper ____

Date of birth _________________________________ Weight ______________________________

Drug Name & Dosage	Schedule/Indications (Per Label)	Health Care Provider Order	Additional Comments
Acetaminophen	Pain / Fever	Yes / No	
Ibuprofen	Pain / Fever	Yes / No	
Robitussin	Cough	Yes / No	
Benadryl	Allergic reaction	Yes /No	
Tums	Upset Stomach	Yes / No	
Sudafed	Nasal Congestion	Yes / No	

Health care provider name: ____

Health care provider signature: ____

Date _______________ Phone # ____

License #____