

MEDICATION PERMISSION FOR SCOUT CAMP

INDIVIDUALIZED ORDERS FOR: Name _____

DOB: _____

Weight: _____

If you wish your child to receive **ANY** medication during camp, the **New York State regulation requires written permission from your health care provider and parent.** This includes all prescriptions and/or over the counter medications. This written permission must be renewed annually.

All medication MUST be in new un-opened bottles with the actual prescription label on them. As well as Epi-pens and Inhalers with the sticker on them for safety reasons.

Standard over the counter/PRN medications (Please list medications approved by the camper's healthcare provider that can be distributed as needed by the camper)

Drug Name	Route (please circle preferred formulation(s))	Dosage	Schedule and Indications	Camper healthcare provider order	Comments
Acetaminophen	PO (chewable tabs, elixir or tabs)	Per label instructions by age/weight	Q 4 hr prn for pain or fever > _____ F	Yes No	
Ibuprofen	PO (elixir or tabs)	Per label instructions by age/weight	Q 6-8 hr prn for pain	Yes No	
Benadryl (or generic equiv.)	PO (elixir or tabs)	Per label instructions by age/weight	Q 6 hr prn for itching or allergic symptoms	Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	

Prescription Medications (Please complete with patient's current regimen for both scheduled and prn medications ; use 2nd page if needed)

Drug Name	Route	Dosage	Schedule and Indications	Comments

Parent/Guardian permission Signature: _____ Date: _____

Camper's Health Care Provider Name: _____ Phone# _____

Address: _____ License # _____

Signature: _____ Date: _____

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