

## OVER-THE-COUNTER MEDICATION ADMINISTRATION AUTHORIZATION FORM

This form must be completed fully and on file in the Infirmary in order for a camper to have formulary list OTC medication (see list below) provided by the camp during a camp day. A new and completed *OTC Medication Authorization Form* is required annually.

In order for non-prescription medication, not on the formulary list below, to be dispensed it must be provided by the parent/guardian in the unopened original container with the label intact. A *Medication Administration Authorization Form*, completed and signed by both a physician and a parent, must accompany the medication.

The Camp Director or Camp Health Supervisor may call the prescriber, as allowed by HIPAA, if a question arises about the camper and/or the camper's medication(s).

### PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME

☐ MALE ☐ FEMALE

2. DATE OF BIRTH

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

3. PARENT/GUARDIAN NAME

4. PHONE

### PRESCRIBERS – Please indicate medications camper may receive

Formulary List Medications	✓ Check here if permitted	Dose (if blank, as directed by package)	PRN for what symptoms	Relevant Side Effects/ Special Instructions
Diphenhydramine HCl Tablets 25 mg each			Itching, sneezing, congestion, allergic response	
Diphenhydramine HCl Liquid			Itching, sneezing, congestion, allergic response	
Hydrocortisone 1% cream		Topical	Itching	
Triple Antibiotic Cream		Topical	Cuts, scrapes	

5. MEDICATION SHALL BE ADMINISTERED

during the year in which this form is dated in 8b below unless more restrictive dates

6 a. FROM

6b. TO

are specified in 6a and 6b. This authorization is **NOT TO EXCEED 1 YEAR**.

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

7. PRESCRIBER'S NAME/TITLE This space may be used for the Prescriber's Address Stamp

TELEPHONE FAX	
ADDRESS	
CITY STATE ZIPCODE	

8a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) 8b. DATE (original signature or signature stamp only - cannot be digital)

### II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication as prescribed by the above prescriber. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

9a. PARENT/GUARDIAN SIGNATURE 9b. DATE

9c. HOME PHONE # 9d. CELL PHONE # 9e. WORK PHONE #

