HF3: 4-H Camp Bristol Hills 2024 MEDICATION APPROVAL

Health Supervisor Check ☐

Camper Name: _____

THIS FORM MUST BE COMPLETED FOR ALL CAMPERS, REGARDLESS OF MEDICATIONS.
A HEALTH CARE PROFESSIONAL'S SIGNATURE IS REQUIRED IF YOUR CHILD IS TO RECEIVE ANY MEDICATION.

If you do not wish for your child to receive any medications, check the box at the bottom of this page and sign that section. If your child requires medication during their stay at camp, you will be required to attend to your child's medications.

Health Care Professional: This patient may receive medications, including prescription and/or over-the-counter, during their time at camp. The Camp Health Supervisor may provide necessary medications (prescription and/or over-the-counter) as needed.

All medications must be given to the Camp Health Supervisor in the ***original container upon arrival at camp,*** with written directions from the licensed Health Care Provider to dispense. ***Our medical staff cannot administer any medication (including over-the-counter medications) without the appropriate signature from the licensed Health Care Professional on this form.***

Over the Counter (OTC) Medications kept on hand in our Infirmary

Drug Name	Route	Dosage	Schedule/Indications	Permission to Administer (circle)
Tylenol	PO (chewable, elixir, or tablets)	Per Label: Instructions by age/weight	Q 4 hr prn for pain or fever >_____°F	YES* or NO
Ibuprofen	PO (chewable tabs, suspension, or tabs)	Per Label: Instructions by age/weight	Q 6 hr prn for pain or fever >_____°F	YES* or NO
Robitussin	(PO) syrup	Per Label: Instructions by age/weight	Q 4 hr prn for cough	YES* or NO
Benadryl	PO (chewable tabs, elixir, or pills)	Per Label: Instructions by age/weight	Q 6hr prn for allergic reaction	YES* or NO
Hydrocortisone Cream 1%	top	Per Label: Instructions by age/weight	For anti-itch	YES* or NO
Antibiotic Crm.	top	Per Label: Instructions by age/weight	For first-aid/pain relief	YES* or NO

Prescription and/or Over the Counter (OTC) Medications Brought to Camp with the Camper

Drug Name	Route (Please enter formulation)	Dosage	Schedule and Indications

This camper may be given any of the above medications as indicated.

Health Care Professional Name: _____ ***Phone:*** _____

Address: _____

Health Care Professional Signature: _____ ***Date:*** _____ ***License #:*** _____

☐ ***NO.*** *I do not authorize any medications (including OTC) to be given to my child while they are at camp. Please contact me in the event that my child would need any medication.* ***Parent/Guardian Signature:*** _____