

FORM G – OVER-THE-COUNTER MEDICATIONS
Return with Forms A, B, C, D, F

THIS FORM REQUIRES PARENT/GUARDIAN'S SIGNATURE
TO AUTHORIZE THE ADMINISTRATION
OF ANY OVER-THE-COUNTER MEDICATIONS

Camper's Name: Last _____ First _____

I DO WISH OVER-THE-COUNTER MEDICATIONS TO BE GIVEN TO MY CHILD.

I understand the Health Care Provider will administer the following over-the-counter medication or the generic version, if necessary, according to directions on the bottles unless a physician directs otherwise. The Camp provides over-the-counter medications.

Symptom:

- Athletes Feet
- Skin irritations
- Minor aches/pain/fever
- Minor cough/sore throat
- Minor Allergic Reactions/Allergies
- Poison Ivy/Rashes
- Bug Bites

- Indigestion/Heartburn
- Constipation
- Clogged Ears
- Open Areas/Cuts

Over-The-Counter Medication:

- Desenex
- Gold Bond Powder
- Tylenol/Advil/Ibuprofen
- Cough Drops/Chloraseptic Throat Spray
- Benadryl
- Calagel Lotion/Calamine Lotion
- Benzocaine Swabs/Dermoplast
- Hydrocortisone Cream/Benadryl Cream
- Antacid/Pepto Bismo/Tums
- Milk of Magnesia
- Auro-Dry
- Bacitracin

If any medication is not listed above, you must obtain a doctor's signature in order for the Camp Nurse to give said medication to your camper.

_____ Date: _____
Signature of Parent or Legal Guardian

Print Parent or Legal Guardian's Name _____

Parent's Home Telephone # or Cell Phone # _____

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I DO NOT WISH ANY MEDICATIONS TO BE GIVEN TO MY CHILD, _____
Camper's Full Name

_____ Date: _____
Signature of Parent or Legal Guardian

Print Name of Parent or Legal Guardian _____

Parent's Home Telephone # or Cell Phone # _____