



2011 CAMPER MEDICATION FORM

CAMP FREDERICK

6996 Millrock Road, Rogers, OH 44455

OFFICE USE ONLY

COUNSELOR: _____

Date of Health Screening: _____

CABIN: _____

Health Center Staff: _____

Camper Name: _____

Birth date: _____ Gender: _____ Age: _____

Program Name: _____ Dates/Year _____

Parent/Guardian: _____

Phone: () _____ Cell Phone: () _____

Parent: Check here if camper needs medications on Sunday Evening.

List any acute or chronic medical or health problems the camper has, including the physician's diagnosis.

1. _____

2. _____

3. _____

SCHEDULED MEDICATIONS:

I request that designated Camp Frederick staff give my child the following medications and/or treatments as indicated.

Drug Name	Dosage	Schedule (Circle below)	Other
1. _____	1x 2x 3x 4x	8am Noon 5pm 9pm	_____
2. _____	1x 2x 3x 4x	8am Noon 5pm 9pm	_____
3. _____	1x 2x 3x 4x	8am Noon 5pm 9pm	_____
4. _____	1x 2x 3x 4x	8am Noon 5pm 9pm	_____

AS NEEDED ONLY MEDICATIONS:

Drug Name	Dosage	Reason	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

INSTRUCTIONS: Place all medications in a paper or plastic bag marked with the camper's name and cabin. Each medication container must be labeled with the camper's name and the name of the medication.

Signature: _____

Relationship to the camper: _____

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PARENT/GUARDIAN AUTHORIZATIONS CAMP MEDICATIONS

The following over-the-counter medications will be available for treating minor complaints. The dosage is determined according to the size/age of child, and the specific directions listed on the medication. Please indicate by circling **YES** or **NO** whether you permit these medications to be used for the conditions indicated.

Camp staff will contact you immediately if illness develops or emergency treatment is required!

MEDICATION: CONDITION

- YES NO **Acetaminophen (Tylenol):** Relief of minor headache or fever
YES NO **Tylenol Cold Formula:** Relief of cold symptoms
YES NO **Ibuprofen:** Relief of inflammation or pain
YES NO **Chloraseptic Spray:** Sore Throat
YES NO **Sore Throat Lozenges:** Sore Throat
YES NO **Sudafed:** Relief of nasal congestion
YES NO **Antihistamine:** Relief of allergy symptoms
YES NO **Kaopectate:** Diarrhea
YES NO **Mylanta, Tums:** Nausea/Vomiting, Indigestion
YES NO **Neosporin/antibiotic ointment:** Treat abrasions/cuts
YES NO **Noxema & Solarcaine:** Treat/relieve minor burns
YES NO **Sunscreen:** Prevent Sunburn
YES NO **Caladryl/Calamine Lotion:** Poison Ivy
YES NO **Hydrocortisone Cream:** Poison Ivy
YES NO **Nox-a-Sting, Cortaid, Sting-Eze:** Insect bites/stings

PERMISSION TO GIVE MEDICINE:

I hereby give permission for the camper previously named to receive the above over-the-counter medications as indicated at the direction and under the supervision of designated Camp Staff.

Signature of Parent/Guardian: _____ **Date:** _____

AUTHORIZATION FOR TREATMENT:

I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medication; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above.
This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian: _____ **Date:** _____

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STAFF USE ONLY

Please initial in the appropriate Day/Time Box for Medications/Treatments.

MEDICATION/TREATMENTS	SCHED	SUN	MON	TUES	WED	THURS	FRI
1.	8 AM						
	12 PM						
	5 PM						
	9 PM						
2.	8 AM						
	12 PM						
	5 PM						
	9 PM						
3.	8 AM						
	12 PM						
	5 PM						
	9 PM						
4.	8 AM						
	12 PM						
	5 PM						
	9 PM						

Name: _____ Initials: _____

Name: _____ Initials: _____

Name: _____ Initials: _____