**Medication Administration Authorization Form**

**Cadet Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ (Last) (First) (MI)

**Medication Allergies**: No \_\_\_\_\_ Yes: \_\_\_\_\_

 If Yes, give name of medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Describe reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check “Yes” to authorize camp nurse/staff to give your child the following medications while on campus. Over-the-counter (OTC) medications are dispensed per package directions unless written directives are provided by a physician.

|  |  |  |
| --- | --- | --- |
| OTC medication dispensed per package instructions: | Indications: | Yes |
| Acetaminophen (Tylenol) | Pain reliever/fever reducer |  |
| Ibuprophen (Advil) | Pain reliever/fever reducer |  |
| Diphenhydramine (Benadryl) | Hay fever or upper respiratory allergies |  |
| Claritin | Hay fever or upper respiratory allergies |  |
| Calcium Carbonate (Tums) | Stomach pain |  |
| Cough drops or throat lozenges | Cough/throat irritation |  |
| Eye drops | Eye irritation |  |
| Loperamide (Imodium) | Diarrhea |  |

**I give permission for the medication(s) listed above to be administered to my child at the Nurse’s discretion or dispensed by designated personnel as delegated by the Camp Nurse. I further give permission for physician-prescribed medications provided by the parent/guardian to be administered according to written directives provided by the physician.**

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_