

Camp Hunt

Standing Orders / Medical Provider Authorization

Camp Hunt
Fax: 888 745 9280

Camper Name: _____ D.O.B. _____

Allergies: _____

Medication	Use	Age	Dose	Allowed ?
Benadryl	Antihistamine	6-12	12.5 - 25 mg po q4-6 hrs	Yes No
Benadryl	Antihistamine	>12	25-50 mg po q4-6 hrs	Yes No
Benadryl - Topical	Itch Relief	All	2% Topical cream/lotion to affected areas	Yes No
Hydrocortisone -Topical	Itch Relief	All	1% Topical cream/lotion to affected areas	Yes No
Ibuprofen	Fever / Pain	6-12	200mg q6-8h (max 1200mg/d; take c̄ food)	Yes No
Ibuprofen	Fever / Pain	>12	200-400mg q6-8h (max 2400mg/d; take c̄ food)	Yes No
Tylenol	Fever / Pain	6-11	10-15 mg/kg (max 5 doses / 24 hrs)	Yes No
Tylenol	Fever / Pain	6-11	325 mg/q 4-6 hrs (max 5 doses/ 24hrs)	Yes No
Tylenol	Fever / Pain	>11	650 - 1000mg/q 4-6 hrs (max dose 4000mg/qd)	Yes No
Loratadine	Allergic Rhinitis	>6	10 mg / qd	Yes No
Sudafed PE -liquid	Decongestant	6-12	10ml(5mg) q4h (max 30mg/qd [6 doses])	Yes No
Sudafed PE	Decongestant	>11	10mg q4h (max 60 mg qd)	Yes No
Chlortrimetron	Allergic Rhinitis	6-12	2 mg q4-6 hrs, or 8mg q12h SR (max 12mg/d)	Yes No
Chlortrimetron	Allergic Rhinitis	>12	4 mg q4-6 hrs, or 8-12mg q12h SR (max 24mg/d)	Yes No
Chloraseptic lozenges	Minor sore throats	>5	1 tab q2h prn dissolved in mouth	Yes No
Chloraseptic Spray	Minor sore throats	2-12	3 sprays q2h prn in mouth	Yes No
Chloraseptic Spray	Minor sore throats	>12	5 sprays q2h prn in mouth	Yes No
Robitussin	Cough	All	Per label, age dependant	Yes No
Tums (Calcium Carbonate)	Dyspepsia	4-11	1 tablet after meals up to 3qd	Yes No
Tums (Calcium Carbonate)	Dyspepsia	>12	2 tablets q4h	Yes No
Junior Maalox Plus	Dyspepsia & Gas	6-11	2 tablets as symptoms occur	Yes No
Maalox Regular Strength	Dyspepsia & Gas	>11	10-20 ml qid (max 60ml qd)	Yes No
Pepto-Bismol	Dyspepsia, Diarrhea	>11	30 ml q1h prn (max 240 ml/d)	Yes No
Imodium	Diarrhea	>8	2mg q8h x 1 day, then 0.1 mg/kg after each loose stool	Yes No
Sunscreen			may self apply	Yes No
Insect Repellent			may self apply	Yes No
All the above medications approved for use as indicated				Yes No

Signing this document allows Camp Hunt's Medical Staff to provide the above approved medications for the listed use(s) only to the camper named above. This document is not intended to replace prescription medications which a camper may need to have provided for him/her during the time he/she is at Camp Hunt.

Provider Name: (MD, DO, RNP, PA) _____

Provider Address: (MD, DO, RNP, PA) _____

Provider Signature: (MD, DO, RNP, PA) _____