CREATIVE SUMMER
At Holton-Arms School 7303 River Road Bethesda MD 20817
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OVER-THE-COUNTER MEDICATION ADMINISTRATION AUTHORIZATION FORM

This form must be completed fully and on file in the Infirmary in order for a camper to have formulary list OTC medication (see list below) provided by the camp during a camp day. A new and completed *OTC Medication Authorization Form* is required annually.

In order for non-prescription medication, not on the formulary list below, to be dispensed it must be in the unopened original container with the label intact and a Medication Administration Authorization form, completed and signed by both physician and parent, must accompany the medication.

The Camp Nurse may call the prescriber, as allowed by HIPAA, if a question arises about the camper and/or the camper's medication(s).

I. PRESCRIBER'S AUTHORIZATION

Child's Name _____ ○ Male ○ Female DOB (mm/dd/yyyy) _____/_____/_____

Parent or Guardian Name: _____ Phone: _____

PHYSICIANS – Please indicate medications camper may receive.

Formulary List Medications	*✓Check here if permitted*	*Dose*	*PRN for what symptoms*	*Relevant Side Effects*	*Special Instructions*
Acetaminophen Tablets 325 mg each	☐		Pain, Fever <100		
Acetaminophen Pediatric Liquid	☐		Pain, Fever <100		
Ibuprofen Tablets 200 mg each	☐		Pain, Fever <100, inflammation		
Ibuprofen Pediatric Liquid	☐		Pain, Fever <100, inflammation		
Diphenhydramine HCl Tablets 25 mg each	☐		Itching, sneezing, congestion, allergic response		
Diphenhydramine HCl Liquid	☐		Itching, sneezing, congestion, allergic response		
Tums >12 year old	☐	2 tablets	Acid indigestion		
Aluminum Hydroxide/Magnesium Hydroxide Tablets	☐	2 tablets	Mild nausea, mild diarrhea		
Hydrocortisone 1% cream	☐	Topical	Itching		
Triple Antibiotic Cream	☐	Topical	Cuts, scrapes		
Medicaine Swabs	☐	Topical	Insect bites, itching		
Mentholyptic Cough Lozenges	☐	1 lozenge	Coughing, sore throat		

12. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 14b below unless more restrictive dates are specified in 12a and 12b. This authorization is ***NOT TO EXCEED 1 YEAR***.

12a. FROM ____/____/____ (Month Day Year)

12b. TO ____/____/____ (Month Day Year)

13. PRESCRIBER'S NAME/TITLE

This space may be used for the Prescriber's Address Stamp

TELEPHONE | FAX

ADDRESS

CITY | STATE | ZIPCODE

14a. PRESCRIBER'S SIGNATURE ***(Parent/guardian cannot sign here)***
(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)

14b. DATE

II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or supervise the camper in self-administration if authorized as prescribed by the above prescriber. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

15a. PARENT/GUARDIAN SIGNATURE

15b. DATE

15c. HOME PHONE # | 15d. CELL PHONE # | 15e. WORK PHONE #