



## Written Doctor and Parent Permission Form

PLEASE NOTE: All medications, vitamins, supplements, or topical treatment require written permission from a physician and parent

Do.D.B   Weight   Allergies   Physician's name:   Physician's na	Camper Last Name			Fi	irst Name		
Physician's name: Phone ##	D.O.B	Weight Allergies					
Physician signature is documented below. Note: All medications must be sent in original packaging.    Property   Physician   P							
Drug Name   Route   Schedule and Indications   To be adminished (feweable tabs, clixir or tabs)   Q 4h as needed for pain or fevers—F   Yes or No	The following over the coustudents. These medication Physician signature is docu	nter medications are ava s can be administered by mented below. Note: <u>All</u>	ilable in the healt y a Registered Nu medications mus	th center. I rse per la t be sent i	It is not necessary to send to bel instructions by age and n original packaging.	hese medica weight only	tions with the if Parent and
Chewable tabs, clixit or tabs    Q 6h as needed for pain or fever>F   YesorNo		İ					To be administered if needed
Chewable tabs, clixir, suspension or tabs    Q4h nasal congestion "not more than 4 doses in 24   Yes or No   Nours   Q2h as needed for sore throat   Yes or No   Q2h for cough   Yes or No   Q2h for cough   Yes or No   Q4h for cough   Yes or No   Q4h for cough   Yes or No   Q4h for cough   Yes or No   Q6h motion sickness   Yes or No   Q6h as needed for allergic reaction, hives, insect   Yes or No   Q6h as needed for allergic reaction, hives, insect   Yes or No   Q6h as needed for allergic reaction, hives, insect   Yes or No   Q6h as needed for allergic reaction, hives, insect   Yes or No   Q6h as needed for allergic reaction, hives, insect   Yes or No   Q6h as needed for allergic reaction, hives, insect   Yes or No   Q6h as needed for allergic reaction, hives, insect   Yes or No   Q6h as needed for allergic reaction, hives, insect   Yes or No   Q6h as needed for allergic reaction, hives, insect   Yes or No   Q6h for allergic reaction, hives, insect   Yes or No   Q6h for allergic reaction, hives, insect   Yes or No   Q6h for allergic reaction, hives, insect   Yes or No   Q6h for allergic reaction, hives, insect   Yes or No   Q6h for itch   Yes or No   Y	Tylenol (Acetaminophen)	By mouth (chewable tabs, elixir or tabs)		Q 4h as needed for pain or fever>F		Yes or No	
Bours   By mouth   Q 2h as needed for sore throat   Yes or No	Motrin (Ibuprofen)	By mouth (chewable tabs, elixir, suspension or tabs)		Q 6h as needed for pain or fever>F		Yes or No	
Robitussin (Guaifenesin)  By mouth (syrup)  Q 4 h for cough  Q 5 h motion sickness  Yes or No  Benadryl (Diphenhydriante  By mouth (Chewable tabs or pills)  Benadryl (Diphenhydramine)  Apply topically  Apply topi	Sudafed	By mouth (tabs)		Q 4h nasal congestion *not more than 4 doses in 24 hours			Yes or No
Dimenhydrinate   By mouth (chewable tabs) 50 mg   Q 6 h motion sickness   Yes or No	Cough drops	By mouth		Q 2h as needed for sore throat		Yes or No	
Benadryl (Diphenhydramine) Benadryl (Diphenhydramine) Benadryl (Diphenhydramine) Benadryl (Diphenhydramine) Claritic, chewable tabs or pills)  Beaitracin Zine 1% Apply topically Apply topica	Robitussin (Guaifenesin)	By mouth (syrup)		Q 4 h for cough		Yes or No	
Sunblock or sunscreen   Apply topically   Apply	Dimenhydrinate	By mouth (chewable tabs) 50 mg		Q 6 h motion sickness		Yes or No	
Bacitracin Zinc 1% Apply topically Q 4 h for signs of irritation to skin Yes or No Hydrocortisone Cream 1% Apply topically Q4 h for itch Yes or No Claritin (loratadine) 10mg By mouth Daily for allergy symptoms Yes or No Zyrtec (cetirizine) 10 mg By Mouth Daily for allergy symptoms Yes or No No Maalox 10 mg By Mouth For stomach upset Yes or No	Benadryl (Diphenhydramine)	By mouth (elixir, chewable tabs or pills)		Q 6 h as needed for allergic reaction, hives, insect bites		Yes or No	
Hydrocortisone Cream 1% Apply topically Q4 h for itch Daily for allergy symptoms Yes or No Claritin (loratadine) 10mg By mouth Daily for allergy symptoms Yes or No Zyrtee (cetirizine) 10 mg By Mouth Daily for allergy symptoms Yes or No Malox 10 mg By Mouth For stomach upset Yes or No Physician Please document below the patient's current medication regime for both scheduled and "as needed" medications routinely received by the above noted minor.  Prescribed Medication Route Dosage Schedule *Be Specific* ie: (qam, qhs,bid,tid,qid)  Self-carry medication release for Sun block, Rescue inhalers, epi—pens and insulin pumps  We request that the above named camper/student be permitted to carry one or all of the following:  (Please check all that apply and indicate MD order above)  Sun block	Sunblock or sunscreen	Apply topically		30 minutes prior to sun exposure as needed for out-door activities		Yes or No	
Claritin (loratadine) 10mg  By mouth  Daily for allergy symptoms  Yes or No  Zyrtec (cetirizine) 10 mg  By Mouth  Daily for allergy symptoms  Yes or No  Maalox 10 mg  By Mouth  For stomach upset  Yes or No  Physician  Please document below the patient's current medication regime for both scheduled and "as needed" medications routinely received by the above noted minor.  Prescribed Medication  Route  Dosage  Schedule *Be Specific* ie: (qam, qhs,bid,tid,qid)  Comments  ie: (qam, qhs,bid,tid,qid)  Comments  We request that the above named camper/student be permitted to carry one or all of the following:  (Please check all that apply and indicate MD order above)  Sun block  Epi-pen  Albuterol Inhaler  Proventil Inhaler  Insulin Pump Pens  Other  Comments:  The above noted 'self-carry" items/medications are permitted for the indicated minor at all times. He/She has been instructed by the physician and parents and acknowledges the proper understanding of the purpose, frequency and appropriate method of use of these items.  As I consider him/ her responsible, I will not hold Frost Valley YMCA personnel responsible for any errors which may arise in my child's self administration of these items/medications.  MUST HAVE THE FOLLOWING SIGNATURES OR NO OVER THE COUNTER, PRESCRIPTION OR SELF-CARRY MEDICATIONS CAN BEADMINISTERED AT CAMP  Physician /Health Care providers Signature:  Phone # Address:	Bacitracin Zinc 1%	Apply topically		Q 4 h for signs of irritation to skin		Yes or No	
Zyrtec (cetirizine) 10 mg By Mouth Daily for allergy symptoms Yes or No  Maalox 10 mg By Mouth For stomach upset Yes or No  Physician  Please document below the patient's current medication regime for both scheduled and "as needed" medications routinely received by the above noted minor.  Prescribed Medication Route Dosage Schedule *Be Specific* le: (qam, qhs,bid,tid,qid)  Self-carry medication release for Sun block, Rescue inhalers, epi—pens and insulin pumps  We request that the above named camper/student be permitted to carry one or all of the following:  (Please check all that apply and indicate MD order above)  Sun block Epi-pen Albuterol Inhaler Proventil Inhaler Insulin Pump Pens Other  Comments:  The above noted 'self-carry" items/medications are permitted for the indicated minor at all times. He/She has been instructed by the physician and parents and acknowledges the proper understanding of the purpose, frequency and appropriate method of use of these items. As I consider him/her responsible, I will not hold Frost Valley YMCA personnel responsible for any errors which may arise in my child's self administration of these items/medications.  MUST HAVE THE FOLLOWING SIGNATURES OR NO OVER THE COUNTER, PRESCRIPTION OR SELF-CARRY MEDICATIONS CAN BEADMINISTERED AT CAMP  Physician /Health Care providers Signature:	Hydrocortisone Cream 1%	Apply topically		Q4 h for itch		Yes or No	
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	Parent Signature:	Address	S:				