Frost Valley YMCA Wellness Center
2000 Frost Valley Road, Claryville, NY 12725
Ph: (845)985-2291 Fax: (845)985-0059 FrostValley.org

Written Doctor and Parent Permission Form

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

Camper Last Name_____**First Name**_____

D.O.B _____ **Weight**_____**Allergies**_____

Physician's name: _____**Phone #**_____

The following over the counter medications are available in the health center. It is not necessary to send these medications with the students. These medications can be administered by a Registered Nurse per label instructions by age and weight only if Parent and Physician signature is documented below. Note: <u>All medications must be sent in original packaging.</u>

Drug Name	Route	Schedule and Indications	To be administered if needed
Tylenol (Acetaminophen)	By mouth (chewable tabs, elixir or tabs)	Q 4h as needed for pain or fever>___-F	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
Sudafed	By mouth (tabs)	Q 4h nasal congestion *not more than 4 doses in 24 hours	Yes or No
Cough drops	By mouth	Q 2h as needed for sore throat	Yes or No
Robitussin (Guaifenesin)	By mouth (syrup)	Q 4 h for cough	Yes or No
Dimenhydrinate	By mouth (chewable tabs) 50 mg	Q 6 h motion sickness	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
Sunblock or sunscreen	Apply topically	30 minutes prior to sun exposure as needed for outdoor activities	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
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

<u>Self-carry medication release for Sun block, Rescue inhalers, epi–pens and insulin pumps</u>

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.

<u>MUST HAVE THE FOLLOWING SIGNATURES</u> OR NO OVER THE COUNTER, PRESCRIPTION OR SELF-CARRY MEDICATIONS CAN BE ADMINISTERED AT CAMP

Physician /Health Care providers Signature: _____

Phone #_____Address: _____

Parent Signature: _____**Date:**_____