

Curtis S. Read Scout Reservation
Summer Camp Over-the-Counter Medications* Permission Form
(To Be Completed Annually and Submitted With Annual Health & Medical Record Forms)

Scout's Information:

Last: _____ First: _____ Camp: _____
 Unit #: _____ Unit Town: _____ Week #: _____

Oral Agents	Dosage	Indication & Schedule	Approved		Initials	Comments
			Yes	No		
Benadryl (Diphenhydramine)	<90#25mg >=90#50mg	Allergic Reaction/Hay Fever Every six hours as needed for 24 hours	yes	no		
Ibuprofen	per label instructions		yes	no		
Imodium	initial 4 tsp repeat 2 tsp max 8 tsp	Diarrhea, as needed for watery stool	yes	no		
Pepto Bismol	per label instructions		yes	no		
Robitussin	per label instructions	Colds, every six hours as needed	yes	no		
Tylenol (Acetamenophen)	per label instructions	Fever, Headache, Pain Control, Toothace every 4 hours as needed	yes	no		
Topical Agents						
Bacitracin	per label instructions	Wound care twice daily as needed	yes	no		
Caladryl	per label instructions	Insect Bites/Poison Ivy twice daily and as needed	yes	no		
Desenex Powder	per label instructions	Athletes Foot twice daily and as needed	yes	no		
Lotrimin	per label instructions	Jock itch three times daily	yes	no		

Insect Repellent & Sunscreen <i>*Brought to camp by Scout, non-aerosol only*</i>	per label instructions	My Son/Daughter may apply or, if requested to a leader, may have applied, insect repellent and sunscreen that he/she has brought to camp.	yes	no	Parent Signature Required here:
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This form MUST be signed by the parent/guardian as well as the Scout's Health Care Provider in order for the above over-the-counter medications* to be received, as per New York State Law.

Health Care Provider: _____ Phone: _____
 Address/City/State/Zip: _____ License #: _____
 Signature: _____ Date: _____

Parent/Guardian Approval: I request that my son/daughter receive the above over-the-counter medications* as indicated by my child's Health Care Provider (Required for under the age of 18).

Parent/Guardian: _____ Phone: _____
 Address/City/State/Zip: _____ Relationship: _____
 Signature: _____ Date: _____

*Specifications for Prescription Medications are to be indicated on Part B of the AHMR.