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
Benadryl (Diphenhydramine)	<90#25mg >=90#50mg	Allergic Reaction/Hay Fever Every six hours as needed for 24 hours	☐ ☐		
Ibuprofen	per label instructions		☐ ☐		
Imodium	initial 4 tsp repeat 2 tsp max 8 tsp	Diarrhea, as needed for watery stool	☐ ☐		
Pepto Bismol	per label instructions		☐ ☐		
Robitussin	per label instructions	Colds, every six hours as needed	☐ ☐		
Tylenol (Acetamenophen)	per label instructions	Fever, Headache, Pain Control, Toothace every 4 hours as needed	☐ ☐		
Topical Agents					
Bacitracin	per label instructions	Wound care twice daily as needed	☐ ☐		
Caladryl	per label instructions	Insect Bites/Poison Ivy twice daily and as needed	☐ ☐		
Desenex Powder	per label instructions	Athletes Foot twice daily and as needed	☐ ☐		
Lotrimin	per label instructions	Jock itch three times daily	☐ ☐		

Insect Repellent & Sunscreen **Brought to camp by Scout, non-aerosol only**	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.	☐ ☐	Parent Signature Required here:

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.