Permission to Administer Over the Counter Medications for Camp

To be completed by the child's health care provider with prescriptive authority:

Child's Name: _____ Child's Birthdate: _____

Applicable Period (Start of Camp Date) 5/31/2026 to (End of Camp Date) 8/7/2026

Medication: Ibuprofen 200mg (Advil) (tablet form)
Authorization: The above over the counter medication:

_____ **IS authorized** to be administered for symptom management for (check all that apply):

- ☐ for pain
- ☐ for cramps

Dosage & Time: (Health Care Provider check ONE option and fill out the information below):

☐ Ibuprofen 200 mg tablet (tablets may be crushed) Give _____mg = _____tablet(s) every 6 hours for indications listed above. Do not exceed 1600 mg (8 tablets) in 24 hours.

Route: Orally/by mouth

Indications/Purpose: For pain and/or cramps.
Special Instructions/Possible Side Effects: _____

_____ **IS NOT authorized** to be administered

Medication: Acetaminophen 325mg (Tylenol) (tablet form)
Authorization: The above over the counter medication:

_____ **IS** authorized to be administered for symptom management for (check all that apply):

- ☐ for fever over 100.4
- ☐ for headache

Dosage & Time: (Health Care Provider check ONE option and fill out the information below):

☐ Tylenol 325 mg tablet (tablets may be crushed) Give _____mg = _____tablet(s) every 6 hours for indications listed above. Do not exceed 2000 mg (6 tablets) in 24 hours.

Route: Orally/by mouth

Indications/Purpose: For headache and/or fever over 100℉.
Special Instructions/Possible Side Effects: _____

_____ **IS NOT** authorized to be administered

Medication: Cetirizine 10 mg (Zyrtec) (tablet form)
Authorization: The above over the counter medication

_____ **IS** authorized to be administered for symptom management for (check all that apply):

- ☐ Itchy, watery eyes
- ☐ Sneezing
- ☐ Runny nose
- ☐ Itchy skin

Dosage & Time: (Health Care Provider check ONE option and fill out the information below):

☐ Cetrizine 10mg tablet (tablets may be crushed) Give _____mg = _____tablet once daily.
Do not exceed 10 mg (1 tablet) in 24 hours.

Route: Orally/by mouth

I**ndications/Purpose**: Seasonal allergy symptoms including itchy, watery eyes, sneezing, runny nose, and/or itchy skin.

Special Instructions/Possible Side Effects: _____

_____ **IS NOT** authorized to be administered

Signature of Healthcare Provider with Prescriptive Authority: _____

Date: _____ **Print Name of Healthcare Provider: _____**

To be completed by the parent or guardian

The parent/guardian of (Child's Name) _____ ask that the camp staff give the following medications as authorized above by my child's health care provider. I understand that **the above OTC's will be provided by the camp**. By signing this document, I give permission to my child's Health Care Provider to share information about the administration of these medications with the authorized camp staff.

Parent/Legal Guardian's Name: _____

Parent/Legal Guardian's Signature: _____ Date: _____

Primary Phone: _____ Alternate Phone: _____
