



HEALTH FORM 2

Requirements for Administration of Medications

Dear Parents,

Under New York law we are only allowed to give campers medications under their doctor's orders.

Prescription Medications

If you wish to send prescription medicine to camp it should be sent in the **original packaging** with a separate note from the doctor with his/her orders. If possible we prefer that these not be sent in the first day. Just drop them off in advance, or send them by U.P.S. or U.S. Postal Service with a return receipt requested. **Please do not send in expired medication as we cannot administer medication that has expired.**

Over The Counter Medications

Deerkill has common over the counter medications at camp, but these can only be given with both your permission and the permission of your doctor. We would, of course, try to call you before giving any of these medications.

The back of this message has a comprehensive form that should be filled in by you and your doctor if you want us to give your child over the counter medication. Please fill it in and send it to us.

Best regards,

Karen and Bob Rhodes

Rebecca Rhodes Rothman and Todd Rothman



HEALTH FORM 2 (CONTINUED)

Over the Counter Medication Sheet

Camper's name: _____

I _____ (physician's name) authorize the following over the counter medications to be given to my patient if necessary.

<p><u>Headaches</u></p> <p><input type="checkbox"/> Tylenol Dose: _____</p> <p><input type="checkbox"/> Advil Dose: _____</p> <p><input type="checkbox"/> Aspirin Dose: _____</p> <p><input type="checkbox"/> Other Dose: _____</p>	<p><u>Coughs & Colds</u></p> <p><input type="checkbox"/> Sudafed Dose: _____</p> <p><input type="checkbox"/> Cough Drops Dose: _____</p> <p><input type="checkbox"/> Throat Spray Dose: _____</p> <p><input type="checkbox"/> Dimetapp Dose: _____</p> <p><input type="checkbox"/> Triaminic Dose: _____</p> <p><input type="checkbox"/> Other Dose: _____</p>	
<p><u>Temperature/Fever</u></p> <p><input type="checkbox"/> Tylenol Dose: _____</p> <p><input type="checkbox"/> Advil Dose: _____</p> <p><input type="checkbox"/> Aspirin Dose: _____</p> <p><input type="checkbox"/> Other Dose: _____</p>	<p><u>Skin Rash/Poison Ivy</u></p> <p><input type="checkbox"/> Calamine Lotion: _____</p> <p><input type="checkbox"/> Technu: _____</p> <p><input type="checkbox"/> Other Dose: _____</p>	<p><u>Fungal (foot)</u></p> <p><input type="checkbox"/> Tinactin Spray</p> <p><input type="checkbox"/> Lotrimin Cream</p> <p><input type="checkbox"/> Other: _____</p>
<p><u>Feminine Cramps</u></p> <p><input type="checkbox"/> Pamprin Dose: _____</p> <p><input type="checkbox"/> Tylenol Dose: _____</p> <p><input type="checkbox"/> Advil Dose: _____</p> <p><input type="checkbox"/> Aleve Dose: _____</p> <p><input type="checkbox"/> Other Dose: _____</p>	<p><u>Muscular Pain</u></p> <p><input type="checkbox"/> Tylenol Dose: _____</p> <p><input type="checkbox"/> Advil Dose: _____</p> <p><input type="checkbox"/> Aspirin Dose: _____</p> <p><input type="checkbox"/> Mineral Ice: _____</p> <p><input type="checkbox"/> BIO-Freeze: _____</p> <p><input type="checkbox"/> Ben Gay: _____</p>	
<p><u>Stomach ache/ Vomiting</u></p> <p><input type="checkbox"/> Pepto Bismol Dose _____</p> <p><input type="checkbox"/> Chewable Antacid Dose: _____</p> <p><input type="checkbox"/> Immodium Dose: _____</p> <p><input type="checkbox"/> Other Dose: _____</p>	<p><u>Allergies/ Insect Bites</u></p> <p><input type="checkbox"/> Hydrocortisone Dose: _____</p> <p><input type="checkbox"/> Chewable Benadryl Dose: _____</p> <p><input type="checkbox"/> Benadryl Liquid Dose: _____</p> <p><input type="checkbox"/> Benadryl Spray/Gel _____</p> <p><input type="checkbox"/> Benadryl Tablets Dose: _____</p> <p><input type="checkbox"/> Other Dose: _____</p>	

Comments: _____

Physician's Signature: _____

Date: _____

Parent's Signature: _____

Date: _____

Reviewed by: _____
(Nurse/Administrator)