

Summer Camp Medical Permission Form Adirondack Scout Camps

Sabattis Scout Reservation
Long Lake, New York

Camp Portaferry
Harrisville, New York

Last: _____ First: _____ Unit: _____

Address: _____ Unit Town: _____

Phone: _____ DOB: _____ Weight: _____

Parent/Guardian Approval: I request that my son/daughter receive the over the counter and prescription medications as indicated my child's Health Care Provider and request self administration of prescription drugs if approved.

Signature: _____

Relationship: _____

Date: _____

| Oral Agents | Dosage | Indication and Schedule | Camper Health Care Provider | | Comments |
|-------------------------------|-------------------------------|--|-----------------------------|----------|----------|
| | | | Approval | Initials | |
| Benadryl (Diphenhydramine) | <90# 25 mg >=90# 50 mg | Allergic reaction/HayFever Every six hours as needed for 24hrs | Yes No | | |
| Imodium | Initial 4 tsp Repeat 2 tsp | Diarrhea as needed for watery stool limit 8tsp | Yes No | | |
| Maalox | 30 cc | Indigestion/Heartburn once | Yes No | | |
| Milk of Magnesia | 30 cc | Constipation daily twice as needed | Yes No | | |
| Robitussin | per label instructions | Colds every six hours as needed | Yes No | | |
| Tylenol (Acetaminophen) | 15 mg / kg (Below) | Fever, Headache, Pain Control, Toothache every 4 hours as needed | Yes No | | |
| Topical Agents | | | | | |
| Bacitracin | per label instructions | Wound care twice daily and as needed | Yes No | | |
| Caladryl | per label instructions | Insect Bites Poison Ivy twice daily and as needed | Yes No | | |
| Desinex Powder | per label instructions | Athletes Foot twice daily and as needed | Yes No | | |
| Lotrimin | per label instructions | Jock itch three times daily | Yes No | | |

| Tylenol Dosing | | | | |
|----------------|--------|--------|--------|---------|
| wt (pounds) | 50-75 | 75-95 | 95-150 | >150 |
| Dose | 325 mg | 500 mg | 650 mg | 1000 mg |

| Prescription Medication | Dosage Route, | Indication Schedule | Camper Health Care Provider Approval | | Comments |
|-------------------------|---------------|---------------------|--------------------------------------|----------|----------|
| | | | Self Administration | Initials | |
| | | | Yes No | | |
| | | | Yes No | | |
| | | | Yes No | | |
| | | | Yes No | | |

Health Care Provider: _____ Phone: _____

Address: _____ License #: _____

Signature: _____ Date: _____