POCONO PLATEAU
CAMP AND RETREAT CENTER

AUTHORIZATION FOR MEDICATION ADMINISTRATION

Due to legal policies governing camp healthcare, all medicines (prescription & non-prescription) not covered by the camp's Standing Orders must have a doctor/health care provider signature below for our healthcare team to dispense to your child.

Pocono Plateau Medication List

The Nurse may dispense this list of medications to your child with your permission from the signed **Camper Health History Form**. Our health care office has the following medications: Acetaminophen (Tylenol-Regular-Strength & Extra-Strength), Ibuprofen (Advil), Naproxen (Aleve), Diphenhydramine Antihistamine (Benadryl),/allergy medicine,Antihistamine/allergy medicine Loratidine (Claritin), Laxatives (Bisacodyl) for constipation, Calaclear for itching, Hall's cough drops, Triple Antibiotic Ointment, Burn gel, Loperamide (Imodium) for diarrhea, Antacids, Hydrocortisone Cream 1%. This is according to our Standing Orders signed by the camp physician.

Child's Full Name _____

Reason for Medication(s) _____

PHYSICIAN CERTIFICATION - I certify that the medication listed below are to be taken during this child's camp week and are medically necessary. This includes prescribed and over the counter medications.

_____ _____ _____ _____

(Health Care Provider Name - Printed) **(Health Care Provider Signature)** (Phone) (Date)

Medication Name(s) / Dosage(s)	**Time(s):** B-Breakfast, L-Lunch, D-Dinner, HS-Bedtime, PRN
	B L D HS Other_____
	B L D HS Other_____
	B L D HS Other_____
	B L D HS Other_____

PARENT/GUARDIAN AUTHORIZATION

I give my consent to the Health Care Staff to administer the above medication(s) to my child/camper

_____ during their time at Pocono Plateau
(Name of Camper)

from _____ thru _____
(Starting Date) *(Closing Date)*

_____ _____.
(*Signature of Parent/Guardian*) Date

THIS SECTION COMPLETED BY HEALTH CARE STAFF ONLY

Name of child is on label Permission form completed Safety type container
Original prescription label, date on prescription label is current/expiration date not passed.
Name of drug, dose, & frequency of administration on label is consistent with instructions given.
OTC, original container, name of drug, dosage, & frequency of administration on label.
Inhaler and/or Epi-Pen w/ camper (will be carried with individual or counselor).

(**Health Care Staff Approval**) ____ **Date:** _______________________