PRESCRIPTION AND OVER-THE-COUNTER MEDICATION RIDER TO HEALTH CONSENT AND RELEASE FORM

NOTICE TO ALL PARENTS WHO HAVE CHILDREN THAT WILL REQUIRE THE ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION OVER-THE-COUNTER MEDICATIONS WHILE ATTENDING CAMP

If your child will be bringing prescription and/or non-prescription over-the-counter medications with them during their time at camp, this form **MUST** be completed by your child's treating physician and provided to the camp **PRIOR** to your child's arrival. There will be no exceptions permitted. In the absence of the completion of this form and timely return to the camp, your child's prescription and/or non-prescription over-the-counter medications cannot be administered and will result in your child's inability to participate in any camp activities and may necessitate their return home.

N.Y.S. Education Scope of Practice Law mandates that we receive a written order from each one of your child's treating physician(s) who have issued them prescription and/or non-prescription over-the-counter medications, so that those prescription and/or non-prescription over-the-counter medications can continue to be administered and distributed to them by our on-site medical personnel while they are at camp. The label on the prescription medication bottle or the instructions that come with the non-prescription over-the-counter medications is not considered a written order and may not reflect the most recent administration requirements. Thus, they may not be relied upon and cannot be used as a substitute for a written order.

You will need to have this form completed by each physician currently prescribing prescriptive and non-prescription over-the-counter medications for your child.

Please have your child's treating physician fill in the below requested information, and then sign and date the form where indicated. Thereafter the completed form(s) **MUST** be returned to the area staff person by email, fax or handing in of form(s) and received by the staff person no later than three (3) days prior to your child's arrival to camp. We strongly urge you to verify the receipt of this form by the area staff person before your child's departure, so no issues will arise during their attendance.

Please be aware that these orders may not be changed verbally and should it become necessary to modify your child's prescription and/or non-prescription over-the-counter medications during their stay with the camp, additional written orders will need to be received from your child's treating physician(s) in order to amend and/or supplement the existing orders.

By your physician completing and signing the annexed form you are hereby giving permission to the licensed medical personnel present at your child's camp to administer and/or oversee the self-administration of the prescription and non-prescription over-the-counter medications in the manner as being directed and provided for herein by your child's physician.

Area #:____________
(Can be found on electronic health form)

Trip Leader: _____________________________

Camp Trip Dates:__________________________

Name: ____DOB: _________ Age ________
Last First Middle Initial

Address____
Street Address City State Zip

Height:___________ Weight: ______________

Parent Name: ____
Last First

Cell phone: (____) ____________________ Home Phone: (____) ______________________

I. Prescription Medications (attach additional signed and dated orders as needed)

Prescription	Manner of administration	Dosage	Schedule and frequency	Special comments

II. Non-Prescription Over-the-Counter Medications (attach additional signed and dated orders as needed)

NOTE: The Over-the-Counter Medications identified on the form may not necessarily identify those over-the-counter prescriptive medications "currently" present in the Infirmary, and thus this form should not be relied upon as an indication that the medication is presently available. Therefore, to the extent that a particular OTC will be required for administration it must be approved by the physician and delivered to the camp at the time of the participant's attendance.

Medications approved for use	**Manner of administration**	**Dosage**	**Schedule and frequency**	**Special comments and Indications for use**
Acetaminophen (Tylenol) Approved (circle): **Yes or No**		Per Label Instructions by age/weight		
Ibuprofen (Advil) Approved (circle): **Yes or No**		Per Label Instructions by age/weight		
Excedrin Extra Strength Approved (circle): **Yes or No**		Per Label Instructions by age/weight		
Midol Approved (circle): **Yes or No**		Per Label Instructions by age/weight		
Day-Quill Approved (circle): **Yes or No**		Per Label Instructions by age/weight		
Ny-Quill Approved (circle): **Yes or No**		Per Label Instructions by age/weight		
Diphen (Benadryl) Approved (circle): **Yes or No**		Per Label Instructions by age/weight		
Loratadine (Claritin) Approved (circle): **Yes or No**		Per Label Instructions by age/weight		
Diamode (Immodium) Approved (circle): **Yes or No**		Per Label Instructions by age/weight		
TUMS Tablets Approved (circle):		Per Label Instructions by age/weight		

Yes or No				
OTHER OTC 1: _____________ Approved (circle): **Yes or No**				
OTHER OTC 2: _____________ Approved (circle): **Yes or No**				
OTHER OTC 3: _____________ Approved (circle): **Yes or No**				

I, a duly licensed physician and/or medical practitioner whose name and signature appear below, does hereby direct the licensed health care provider at the camp to administer or oversee the self-administration of the aforementioned prescriptive and non-prescriptive over-the-counter medications in the manner, dosage, schedule, indications and frequency as herein directed by this order. This order may not be changed verbally and should it become necessary to amend and/or supplement this order a further written order will be issued.

Child's Name: ____

Name of Prescribing Physician: ____

Address: ____

Telephone number: ____

Specific directions other than as set forth above:

____

____

____

____

Physician's Signature: ____

Dated: ____