PLEASE NOTE: The NYS Department of Health requires that a medical authorization form, filled in *by a physician,* be submitted for each camper in order for the camper to be given any medication (prescription or over-the-counter). We are not requiring a physical examination. Some doctors will fill in this form without an office visit; others prefer not to do it by mail. This form must be returned to us two weeks prior to the camper period. The camp is prohibited by law to dispense any medication to your child without this signed form. Thankyou.

PILGRIM CAMP

1542 Palisades Road . Brant Lake, NY 12815 (518) 494-2547

MEDICAL AUTHORIZATION FORM

CAMPER _____ Date of Birth _____

ADDRESS _____ Phone _____

PRESCRIPTION MEDICATIONS: Physician: Please list all prescription medications patient uses on a regular basis. (attach extra sheet if necessary)

Drug Name	Route	Dosage	Schedule and Indications	Comments

Physician: Please list all prescription medications patient uses only when necessary. (attach extra sheet if necessary)

Drug Name	Route	Dosage	Schedule and Indications	Comments

STANDARD OVER THE COUNTER/PRN MEDICATIONS: Physician: the following medications are available in our camp infirmary and will be administered at the discretion of an RN if you indicate approval by signing below. Please mark if specific medication SHOULD NOT be administered to patient.

Drug Name	Route	Dosage and Schedule	Check only if Patient may not take medication	Comments
Tylenol (or generic)	PO (chewable, elixir or tabs) PR (suppository)	Per label instructions by age/weight	☐ May not take	
Ibuprofin	PO (chewable, elixir or tabs) PR (suppository)	Per label instructions by age/weight	☐ May not take	
Robitussin (or generic)	PO (syrup)	Per label instructions by age/weight	☐ May not take	
Pepto-Bismol (or generic)	PO (liquid or chewable tabs)	Per label instructions by age/weight	☐ May not take	
Kaopectate (or generic)	PO (liquid or tabs)	Per label instructions by age/weight	☐ May not take	
Children's Mylanta (or generic)	PO (chewable tabs)	Per label instructions by age/weight	☐ May not take	
Sudafed (or generic)	PO (liquid or tabs)	Per label instructions by age/weight	☐ May not take	
Chlorpheniramine	PO (chewable tabs, suspension or tabs)	Per label instructions by age/weight	☐ May not take	
Dramamine/Bonine (or generic)	PO (chewable or regular tabs)	Per label instructions by age/weight	☐ May not take	
Benadryl (or generic)	PO/Topical (elixir, chewable tabs, pills or topical ointment)	Per label instructions by age/weight	☐ May not take	
Antibiotic Ointment	Topical	Per label instructions	☐ May not take	
Hydrocortisone Cream	Topical	Per label instructions	☐ May not take	
Antifungal Cream	Topical	Per label instructions	☐ May not take	

To the best of my knowledge, the above information is true and correct.

PHYSICIAN'S PRINTED NAME _____ PHYSICIAN'S SIGNATURE _____ DATE _____

PHYSICIAN'S ADDRESS (number & street, city, state, ZIP) _____ PHONE (area code and number) _____

PARENT/GUARDIAN SIGNATURE (REQUIRED). By signing this I agree and understand in the case of a medical emergency that every effort will be made to contact the parents or guardians of the camper. In the event I cannot be reached, I give permission to the camp-selected physician to refer campers to Hudson Headwaters Health Network, Glens Falls Hospital, or another facility/clinic--and to secure proper treatment for, and to order anesthesia or surgery for my child.

PARENT/GUARDIAN PRINTED NAME _____ PARENT/GUARDIAN SIGNATURE _____ DATE _____

EMERGENCY PHONE CONTACT NUMBER 1 _____ EMERGENCY PHONE CONTACT NUMBER 2 _____ EMERGENCY PHONE CONTACT NUMBER 3 _____