MEDICAL AUTHORIZATION FORM

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

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 dispensed 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 the camp two weeks prior to the camper period. We are prohibited by law to dispense any medication to your child without this signed form. Thankyou.

Camper_____ Date of Birth _____

Address _____ Phone _____

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

Drug Name	Route	Dosage	Schedule and Indications	Comments

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

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 or medications **SHOULD NOT** be administered to the patient.

Drug Name	Route	Dosage and Schedule	Check if patient may not take	Comments
Tylenol (or generic)	Elixir or Tablets	Per label by	☐ May not take	
Ibuprofen (or generic) / Motrin / Iprin	Elixir or Tablets	Per label by age/weight	☐ May not take	
Robitussin (or generic)	Syrup	Per label instructions	☐ May not take	
Sudafed (or generic(	Syrup or tabs	Per label by age/weight	☐ May not take	
Gold Bond Powder	Topical	Per label instructions	☐ May not take	
Tums	PO	Per label instructions	☐ May not take	
Halls or Ricola Cough Drops	PO	Per label instructions	☐ May not take	
Claritin (or generic)	PO	Per label instructions	☐ May not take	
Insect Spray	Topical	Per label instructions	☐ May not take	
Hydrocortisone / Caladryl	Topical	Per label instructions	☐ May not take	
Bacitracin Ointment	Topical	Per label instructions	☐ May not take	
Saline or Distilled Water	Eye Wash	Per label instructions	☐ May not take	
Debrox Eardrops	Ear Treatment	Per label instructions	☐ May not take	
Apple With Skin / Prune Juice	PO		☐ May not take	

PARENT/GUARDIAN SIGNATURE. By signing below, I agree that in the case of an emergency every effort will be made to contact the parents/guardians of the camper. In the event I cannot be reached I give permission to camp-selected physicians to hospitalize, secure proper treatment for and to order anesthesia or surgery for my child. I also consent to having our child use sunscreen and insect repellant he/she has brought or which the camp has supplied—and which may be applied by an unlicensed camp staff member if the camper requests.

_____ _____ _____

PARENT/GUARDIAN PRINTED NAME PARENT/GUARDIAN SIGNATURE DATE

IMMUNIZATIONS. List most recent dates of inoculations or booster shots.

DTP (DTaP _____ **Td** _____ **Polio** _____ **MMR** _____

(Month/ /Day/Year) (Month/ /Day/Year) (Month/ /Day/Year) (Month/ /Day/Year)

Hib _____ **Hep B** _____ **Chickenpox** _____

(Month/ /Day/Year) (Month/ /Day/Year) (Month/ /Day/Year)

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT.

_____ _____ _____

PHYSICIAN'S PRINTED NAME PHYSICIAN'S SIGNATURE DATE

_____ _____

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