## HAPPY CAMPERS

## OVER-THE-COUNTER MEDICATION ADMINISTRATION AUTHORIZATION

Dear Physician:
Please indicate the medications you authorize for _____. In the event that any medication is needed at the Happy Campers Program, parents will also authorize medication administration. No medication will be dispensed without prior physician and parent authorization.

| | |
|---|---|
| ❑ Acetaminophen (Tylenol/Tempra) | _____cc/tsp/mg per 4 hours prn |
| ❑ Benadryl/diphenhydramine | _____tsp/mg per 4-6 hours prn |
| ❑ Dimetapp/Dimetapp DM | _____tsp per 6 hours prn |
| ❑ (infant decongestant drops) | _____dropper(s) per 6 hours prn |
| ❑ Ibuprofen (Motrin/Advil) | _____tsp/mg per 6 hours prn |
| ❑ Mylicon | _____dropper(s) prn |
| ❑ Orajel | _____apply to gums prn |
| ❑ PediAcare (infant-decongestant) | _____dropper(s) per 4-6 hours prn |
| ❑ (infant-decongestant/cough) | _____dropper(s) per 4-6 hours prn |
| ❑ Robitussin/DM/CF | _____tsp per 4-6 hours prn |
| ❑ Triaminic | _____tsp per 6 hours prn |
| ❑ _____ | _____tsp/mg ___times/day prn |
| ❑ _____ | _____tsp/mg ___times/day prn |
| ❑ _____ | _____tsp/mg ___times/day prn |
| | |
| ❑ Albuterol (via nebulizer) | _____amp/mL ___times/day |
| ❑ Cromolyn (via nebulizer) | _____cc/ns |
| ❑ Ointment(s): _____ | _____apply to skin prn |
| ❑ Other: _____ | _____tsp/mg/gtts ____times/day prn |
| ❑ Other: _____ | _____tsp/mg/gtts ____times/day prn |
| ❑ Other: _____ | _____tsp/mg/gtts ____times/day prn |

Comments: _____
_____
_____
_____
_____

Physician's Signature: _____ Date:_____

Print Physician's Name: _____

Parent/Guardian Signature: _____ Date: _____