Gretna Glen Camp & Retreat Center 2015

AUTHORIZATION FOR MEDICATION ADMINISTRATION

Questions Call: 717-273-6525

Due to legal policies that govern healthcare at camps, all medications that are not listed under the Gretna Glen Medication List below, whether prescribed or over the counter must have a doctor/health care providers signature on this document for our healthcare team to dispense to your child.

Gretna Glen Medication List

Gretna Glen 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), Ibuprofen(advil, motrin), diphenhydramine antihistamine/allergy medicine (Benadryl), Tums, non-sedating Antihistamine/allergy medicine loratidine (Claritin), laxatives for constipation (Milk of Magnesia), Sore throat spray, calamine lotion, cough drops, antibiotic cream, aloe or burn gel, bismuth subsalicylate/loperamide for diarrhea (Pepto Bismol, Imodium), Antacids (Tums), hydrocortisone cream 1%

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) **(Health Care Provider Signature)** (Phone) (Date)

_____ _____ _____ _____

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

PARENT/GAURDIAN AUTHORIZATION

I, _____ give my consent to the Health Care
(Name of Parent/Guardian)
Staff to administer the above medication(s) to my child/camper_____
(Name of Camper)
during their time at Gretna Glen from _____ through _____
(Starting Date) (Closing Date)

(Signature of Parent/Guardian) _____ Date _____

THIS SECTION COMPLETED BY HEALTH CARE STAFF ONLY

☐ Permission form completed ☐ Safety type container ☐ Original prescription label ☐ Name of child is on label
☐ Date on label is current ☐ OTC, original container and current ☐ Name of drug, dose, & frequency of admin on label
☐ Inhaler and/or Epi-Pen w/ camper (either with individual or counselor

(**Health Care Staff Approval**) _____