

# CAMP OLMSTED MEDICATION & EMERGENCY CONSENT

## For Medical Treatment Form

### APPOINTMENT OF LEGAL REPRESENTATIVE TO AUTHORIZE TREATMENT OF MINOR

**I am the parent or legal guardian of the following minor child (under 18):**

Child's Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of last tetanus or D.P.T: \_\_\_\_\_ Any specific medical condition or known allergies: \_\_\_\_\_

**Prescription or "over-the-counter" medication should be in its original container and placed in a zip-lock bag for transportation to the camp with a note authorizing the nurse to dispense medication. All medication will be distributed by the camp nurse at the prescribed times. All medication should have the child's name on it.**

**Must be signed & stamped by the doctor if child takes prescription medication**

### Prescription Medications

*Must complete with camper's current regimen for both scheduled and PRN medications (use 2<sup>nd</sup> page if needed)*

DRUG NAME	ROUTE	DOSAGE	SCHEDULE & INDICATIONS	COMMENTS

### Health Care Provider (MD, NP, PA)

Child's Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Pediatrician's Signature \_\_\_\_\_ License # \_\_\_\_\_

### Standard over the Counter Medications

**No over-the-counter medications can be dispensed without completion of this form.**

*Any over the counter medications the student plans to bring to camp must be added to this list.*

DRUG NAME	ROUTE [PLEASE CIRCLE PREFERRED FORMULATION(S)]	DOSAGE	SCHEDULE & INDICATIONS	CAMPER HEALTHCARE PROVIDER ORDER	COMMENTS
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

### Standard Over the Counter Medications provided at Camp Olmsted include:

*Please indicate if your child CAN NOT receive any of the following.*

- |                              |  |
|------------------------------|--|
| • Acetaminophen (Tylenol)    | <input type="checkbox"/> DO NOT give my child Acetaminophen (Tylenol)    |
| • Ibuprofen (Advil, Motrin)  | <input type="checkbox"/> DO NOT give my child Ibuprofen (Advil, Motrin)  |
| • Phenylephrine (Sudafed PE) | <input type="checkbox"/> DO NOT give my child Phenylephrine (Sudafed PE) |
| • Pseudoephedrine (Sudafed)  | <input type="checkbox"/> DO NOT give my child Pseudoephedrine (Sudafed)  |

- Chlorpheniramine Maleate  DO NOT give my child Chlorpheniramine Maleate
- Guaifenesin  DO NOT give my child Guaifenesin
- Dextromethorphan  DO NOT give my child Dextromethorphan
- Diphenhydramine (Benadryl)  DO NOT give my child Diphenhydramine (Benadryl)
- Generic Cough Drops  DO NOT give my child Generic Cough Drops
- Chloraseptic (Sore throat spray)  DO NOT give my child Chloraseptic (Sore throat spray)
- Lice Shampoo/scabies cream (Nix or Elimite)  DO NOT give my child Lice Shampoo or scabies cream (Nix or Elimite)
- Calamine Lotion  DO NOT give my child Calamine Lotion
- Bismuth Subsalicylate (Pepto-Bismol)  DO NOT give my child Bismuth Subsalicylate (Pepto-Bismol)
- Laxative for constipation  DO NOT give my child Laxative for constipation
- Hydrocortisone 1% cream  DO NOT give my child Hydrocortisone 1% cream
- Topical Antibiotic Cream  DO NOT give my child Topical Antibiotic Cream
- Aloe  DO NOT give my child Aloe

**For more information on these medications please consult your child's health care provider.**

**Emergency Contacts**

*In the event of an emergency, please list your contact information and two additional contacts.*

Guardian I: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Guardian I: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Guardian I: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

**I hereby give permission to the medical personnel appointed by the management of Camp Olmsted, located at 114 Bay View Avenue in Cornwall-on-Hudson, New York to provide routine health care; to administer medications; to order x-rays, routine tests, and treatment; to release any medical records necessary for treatment or insurance purposes; and to provide and/or arrange any necessary transportation for my child.**

**In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer any and all treatment, including hospitalization for the minor named above. This form may be photocopied for trips away from the camp property.**

**I understand and agree that I am responsible for the charges incurred for authorized care rendered for the above named minor. This authorization will expire on the child's 18<sup>th</sup> birthday, and may be revoked in writing at any time.**

\_\_\_\_\_  
Print Name of Parent or Guardian

\_\_\_\_\_  
Address

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date