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 prn
- 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: _____________