Mandaville
Camp & Retreat Center
165 Sheldon Rd, Winthrop, NY 13697
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Parent and Health Care Provider

Authorization for Administration of Medication

To be completed by child's Health Care Provider:

1. Child's Name_____ DOB_____ Age_____

   Weight_____ Height_____

2. Allergies_____

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3. Provider's Orders for Prescription Medication to be given at camp: (please note… if child takes medications while in school, he/she should take them at camp.)

Diagnosis:	Medication:	Route:	Dosage:	Frequency:

**** Please include all prescriptions, over the counter medications, vitamins, eye drops, lotion, inhalers, etc. ****

4. Does this child have a serious medical condition that requires him/her to carry an epi pen or inhaler? Yes / No

If yes: What is the child's condition?_____

Medication?_____

Do you authorize the child to carry the medication on his/her own person and to self administer as needed? Yes / No

Has the child been instructed in and understands the purpose, appropriate method and frequency of use, and to inform camp medical personnel when medication has been used? Yes / No

5. The following are over the counter medications available at Mandaville's Health Center. A Child Health Care Provider (**HCP**) must indicate dosage and circle "Yes" **IF** they wish to have this child receive these as needed while at camp.

Medication:	Route:	Dosage:	Frequency:	Child's HCP Order
Tylenol	Oral (tabs, chew tabs, liquid)		Every 4 hours for pain as needed or fever >101	**Yes / No**
Ibuprofen	Oral (tabs, chew tabs, liquid)		Every 6 hours as needed for pain	**Yes / No**
Peptobismol Tums	Oral (tabs, chew tabs, liquid)		Every 30 min up to 1 hr as needed for diarrhea, sour stomach	**Yes / No**
Benadryl	Oral (liquid, tabs, chew tabs) Topical (gel, lotion)		Every 4-6 hours for allergic reactions (hives, insect bites	**Yes / No**
Robitussin	Oral (liquid)		Every 4-6 hours for cough, sore throat, runny nose, stuffy nose	**Yes / No**
Refresh eye drops	Eye drops		As needed for eye dryness or cleaning out eyes	**Yes / No**
Triaminic Cold & Cough	Oral (liquid)		Every 4-6 hours for cough, sore throat, runny nose, stuffy nose	**Yes / No**
Midol	Oral (tabs)		Every 6 hours as needed for pain	**Yes / No**

6. **Health Care Provider's Signature**_____

Date:_____ License #_____

Phone_____

To be completed by parent/guardian

7. I give permission for my child to receive the medication(s) as prescribed by our licensed health care provider. The medication listed in section 2 is to be furnished by me in the properly labeled original container from the pharmacy. If there are any changes since this was completed, I will bring a not from the Dr. Explaining the changes. Medications listed in section 5 will be provided by Mandaville Camp & Retreat Center. I understand that my child will be supervised by Mandaville Camp & Retreat Center's staff in taking his/her medications.

Parent / Guardian Signature_____ Date_____