



Lancaster Presbyterian Church

Name _____		
Office Use Only	<input type="checkbox"/> Elementary	Cabin # _____
	<input type="checkbox"/> Intermediate	Tent # _____
	<input type="checkbox"/> Junior High	Lodge or Cabin # _____
Dates of Camp: <u>Sunday, June 24 – Saturday, June 30, 2018</u>		

Over the Counter Medication Approval Form

Summer Youth Camp 2018

Name of Camper: _____

Date of physical: ____/____/____ (date of physical must be within one year of attending camp)

Over the Counter Medications

***This form MUST be completed by the child's medical doctor.**

I hereby authorize that following medications may be given to the above named child after the nursing assessment.

- Bactine** (topical) for minor wound care, first aid as needed
- Triple Antibiotic Ointment** (topical) for wound healing
- Tylenol** (oral) as directed on bottle
- Ibuprophen** (oral) as directed on bottle
- Cough Drops** for coughing, minor throat irritation as needed
- Antacid Tablet** (oral) for stomach discomfort
- Benadryl** (oral or topical) for swelling, hives, allergic reaction as directed on bottle
- Calamine Lotion or Cortaid** (topical) for insect bites/bee stings
- Visine/ Murine Plus Eye Drops** (topical in eye) for minor eye irritation
- Other** (please describe) _____

Physicians Consent

Physician Signature _____ Date _____

Printed Name _____ License Number _____

Address _____ Phone _____

City _____ State _____ Zip _____ Fax _____