

Summer Camp Medical Permission Form Adirondack Scout Camps

Sabattis Scout Reservation
Long Lake, New York

Cub Camps

Last: _____ First: _____ Unit: _____

Address: _____ Unit Town: _____

Phone: _____ DOB: _____ Weight: _____

Parent/Guardian Approval: I request that my son/daughter receive the over the counter and prescription medications as indicated my child's Health Care Provider and request self administration of prescription drugs if approved.

Signature: _____ Relationship: _____ Date: _____

Oral Agents	Dosage	Indication and Schedule	Camper Health Care Provider		Comments
			Approval	Initials	
Benadryl (Diphenhydramine)	<90# 25 mg >=90# 50 mg	Allergic Reaction/Hay Fever every six hrs as needed for 24 hours	yes	no	
Immodium	initial 4 tsp repeat 2 tsp	Diarrhea as needed for watery stool limit 8 tsp	yes	no	
Maalox	30 cc	Indigestion/Heartburn once	yes	no	
Milk of Magnesia	30 cc	Constipation daily twice as needed	yes	no	
Robitussin	per label instructions	Colds every six hours as needed	yes	no	
Tylenol (Acetaminophen)	15 mg/kg (below)	Fever, Headache, Pain Control, Toothache every 4 hours as needed	yes	no	
Topical Agents					
Bacitracin	per label instructions	Wound Care twice daily and as needed	yes	no	
Caladryl	per label instructions	Insect Bites/Poison Ivy twice daily and as needed	yes	no	
Desinex Powder	per label instructions	Athletes Foot twice daily and as needed	yes	no	
Lotrimin	per label instructions	Jock Itch three times daily	yes	no	

Tylenol Dosing				
wt (pounds)	50-75	75-95	95-150	>150
Dose	325 mg	500 mg	650 mg	1000 mg

Prescription Medication	Dosage and Route	Indication and Schedule	Camper Health Care Provider Approval		Comments
			Self Administration	Initials	
			yes	no	
			yes	no	
			yes	no	
			yes	no	

Health Care Provider: _____ Phone: _____

Address: _____ License #: _____

Signature: _____ :Date: _____