SENECA WATERWAYS COUNCIL BOY SCOUTS OF AMERICA
Summer Camp Youth Medication Permission Form

Last Name:_____ First Name:_____ Unit:_____

Street:_____ City/State:_____

Phone:_____ Date of Birth:_____ Weight:_____

Oral Agents	Dosage	Indication and Schedule	Camper Health Care Provider Approval		Initials	Comments
Diphenhydramine (such as Benadryl)	<90# 25 mg >= 90# 50 mg	Allergic Reaction/ Hay Fever every six hours as needed for 24 hours	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		
Acetaminophen (such as Tylenol)	15 mg/kg (below)	Fever, Headache, Pain Control, Toothache every 4 hours as needed	Yes	No		
Ibuprofen (such as Motrin)	200 mg	Fever, Pain every 6 hours as needed	Yes	No		
Ibuprofen Liquid (such as Motrin)	5 ml per wt (below)	Fever, Pain every 6 hours as needed	Yes	No		
Topical Agents	**Dosage**	**Indication and Schedule**	**Camper Health Care Provider Approval**		**Initials**	**Comments**
Triple Antibiotic (such as Neosporin)	Per label instructions	Wound care (scrapes, poison ivy) twice daily as needed	Yes	No		
Pramoxine (such as Caladryl)	Per label instructions	Insect Bites/ Poison Ivy twice daily as needed	Yes	No		
Miconazole Powder (such as Desenex)	Per label instructions	Athletes Foot twice daily as needed	Yes	No		
Clotrimazole (such as Lotrimin)	Per label instructions	Jock Itch three times daily	Yes	No		

Acetaminophen Dosing				
weight	50-75 lbs	75-95 lbs	95-150 lbs	>150 lbs
Dose	325 mg	500 mg	650 mg	1000 mg

Ibuprofen dosing				
weight	48-59 lb	60-71 lb	72-95 lb	96+ lb
Liguid	10 ml	12.5 ml	15 ml	20 ml
200mg tablet	1 tab	1 tab	1 1/2 tab	2 tab

Prescription or OTC medication	Dosage / Route	Indication and Schedule	Camper Health Care Provider Self-Administration		Initials	Comments
			Yes	No		
			Yes	No		

Health Care Provider:_____ Phone:_____

Address:_____ License:_____

Signature:_____ Date:_____

I hereby give permission for my son/ daughter receive over the counter and prescription medications as indicated by my child's Health Care Provider and request self-administration of prescription drugs. In addition, I give permission to carry and use sunscreen or insect repellent at camp and to use it throughout the day. If my child needs help re-applying sunscreen or insect repellent, I give permission for camp staff to provide my child with assistance if he/she requests it.

Signature of Parent or Guardian:_____ Date:_____