Mandaville
Camp & Retreat Center
165 Sheldon Rd, Winthrop, NY 13697
Ph: 315-328-4581; email: director@campmandaville.org

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, 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 Camp Mandaville 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
GI Medications: Pepto-Bismol, Tums, Simethicone, mineral oil	Oral (tabs, chew tabs, liquid)		Use as directed	Yes / No
Benadryl	Oral (liquid, tabs, chew tabs,) Topical (gel, lotion)		Every 4-6 hours for allergic reactions (hives, insect bites)	Yes / No
Menthol Cough Drops	Oral		1 PO/PRN	Yes / No
Refresh Eye drops	Eye drops		As needed for eye dryness or cleaning out eyes	Yes / No
Cold & Cough (Acetaminophen Dextromethorphan Phenylephrine)	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
Neosporin	Cream		Apply as needed	Yes / No
Hydrocortisone	Cream		Apply as needed	Yes / No
Benadryl (diphenhydramine)	Cream		Apply as needed	Yes / No
Pain Relief Spray (Lidocaine)	Spray		Apply PRN/BID	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 note from the Dr. explaining the changes. Medications listed in section 5 will be provided by Camp Mandaville. I understand that my child will be supervised by Camp Mandaville staff in taking his/her medications.

Parent / Guardian Signature _____ Date_____