Citta Scout Reservation Over the Counter Medication Information

Camper's Name: _____ Unit #: _____Age: _____

The Citta Scout Reservation Health Officer has the following over the counter medications available for your scout should he/she need any. This form indicates which medication(s) you will allow our Health Officer to dispense should the event arise. Please initial the medications you give permission for our Health Officer to dispense to your child by completing **Option A**. If you do **NOT** wish for your child to be given any over the counter medications during his/her stay, please indicate that below by completing **Option B**.

Name of Medication	Dosage	Reason	Initial of Parent/Guardian
Acetaminophen 250mg	As directed on package for age/weight	Minor pain, fever, muscle aches, cramps	
Tylenol, Chewable	As directed on package for age/weight	Minor pain, fever, muscle aches, cramps	
Ibuprofen/ Advil 200mg	As directed on package for age/weight	Minor pain, fever, muscle aches, cramps	
Calamine lotion	As directed on package	Insect bites, bee stings	
Pepto-Bismol	As directed on package for age/weight	Diarrhea, Nausea, Stomach discomfort	
Benadryl 25 mg	As directed on package for age/weight	itching	
Loratadine 10 mg	As directed on package for age/weight	Seasonal allergies	
Robotussin	As directed on package for age/weight	Cough	
Chloraseptic Lozenges	As directed on package	Sore Throat as needed	
Triple Antibiotic	As directed on package	Wound healing	
Tums	As directed on package	Stomach discomfort	
Sunscreen/Aloe +30 SPF	As directed on package	Sun protection/ sunburn care	
Bug Spray-NON deet	As directed on package	Bug protection	

Option A: Allow Meds as Needed

As parent or legal guardian of the above-named child, **I give the Health Officer permission** to administer the medications that I have initialed. I understand that if I have NOT initialed the item, the Health Officer will not be able to administer any medications.

Date: _____ Parent/Guardian Signature: _____ Phone number: _____

Option B: No Over the Counter Medication Permitted

As parent or legal guardian of the above-named child **I do NOT want the Health Officer to administer** any over the counter medications. In the event my child needs one of the medications listed, the Health Officer should contact me.
Please Provide Contact Information:

Date: _____ Parent/Guardian Signature: _____

Parent/Guardian Name (Please Print): _____ Phone Number: _____