This form must be filled out and signed by a parent and physician

Frost Valley YMCA Guenther Family Wellness Center

Written Physician & Parent Permission Form

2000 Frost Valley Road, Claryville, NY 12725 **Tel:** 845.985.2291 **Fax:** 845.985.0059

STUDENT NAME: _____ **DATE OF BIRTH:** _____

SCHOOL NAME: _____

PHYSICIAN'S NAME: _____ **PHONE:** _____

The following overy they counter medications are available at the Wellness Center, and can be administered as needed per label instructions by age and weight of the student. **PLEASE NOTE:** Absolutely **NO** overy they counter or prescription medications, supplements, vitamins, or topical ointments can be administered without a physician and parent's signature , in accordance with New York State Education Law, Title 139, Section 6902.

ALL MEDICATIONS SENT TO CAMP MUST BE SENT IN THEIR ORIGINAL CONTAINERS WITH LABELING INTACT

TO THE PROVIDER: Please, indicate approval for administration by circling yes or no in the space indicated.

MEDICATION	ROUTE	DOSAGE	SCHEDULE & INDICATIONS	MAY BE ADMINISTERED
Tylenol (Acetaminophen)	By mouth (elixir or tablets)	Per label instructions By age and weight	Every 4 hours PRN pain or fever > _____°F	Yes No
Motrin (Ibuprofen)	By mouth (elixir, suspension or tablets)	Per label instructions By age and weight	Every 4 hours PRN pain or fever > _____°F	Yes No
Phenylephrine HCl	By mouth (tablets)	Per label instructions By age and weight	Every 4 hours PRN nasal congestion	Yes No
Robitussin (Guaifenesin)	By mouth (syrup)	Per label instructions	Every 4 hours PRN cough	Yes No
Dramamine (Dimenhydrinate)	By mouth (chewable tabs or tablets)	Per label instructions By age and weight	Every 6 hours PRN motion sickness	Yes No
Benadryl (Diphenhydramine)	By mouth (elixir, tablets or capsules) Apply topically	Per label instructions By age and weight	Every 6 hours PRN allergies, or insect bites	Yes No
Claritin (Loratadine)	By mouth (tablets)	10 mg	Daily PRN allergy symptoms	Yes No
Zyrtec (Cetirizine HCl)	By mouth (tablets)	10 mg	Daily PRN allergy symptoms	Yes No
Allegra (Fexofenadine)	By mouth (tablets)	180 mg	Daily PRN allergy symptoms	Yes No
Tums (Calcium Carbonate)	By mouth (tablets)	840 mg	Every 2 hours PRN acid indigestion	Yes No
Imodium	By mouth (tabs or capsules)	Per label instructions	After loose stools	Yes No
Lactaid (Lactase)	By mouth (caplets)	Three caplets	With first bite of dairy	Yes No
Maalox	By mouth (suspension)	10 mL	Every 4 hours PRN upset stomach	Yes No
Sunblock or Sunscreen	Apply topically	SPF ≥30	Apply PRN prior to sun exposure	Yes No
Insect Repellant	Apply topically	Aerosol or pump	Per label instructions	Yes No
Bacitracin Ointment	Apply topically	Bacitracin Zinc 500 U	Apply 1-3x Daily PRN minor cuts	Yes No
Hydrocortisone Cream 1%	Apply topically	Hydrocortisone 1%	Apply 3-4x Daily PRN skin irritation	Yes No
Antifungal Cream	Apply topically	Tolnaftate 1%	Apply twice daily to soothe itching	Yes No
Calamine Lotion	Apply topically	Per label instructions	As needed PRN itching	Yes No

PROVIDER: Please document below the current medication regimen for the above-stated student, including scheduled and PRN medications.

MEDICATION	ROUTE	DOSAGE	SCHEDULE	COMMENTS

The above-stated student may self-carry the following items and/or medications (select all that apply):

☐ Sunblock ☐ Epi-Pen ☐ Albuterol Inhaler ☐ Proventil Inhaler ☐ Insulin Pump Pens ☐ Other:_____

The above noted "self-carry" items/medications are permitted for the indicated minor at all times. He/she has been instructed by the physician and acknowledges the proper understanding of the purpose, frequency, and appropriate method of use of these items and/or medications. As I consider him/her responsible, I will not hold Frost Valley YMCA personnel responsible for any errors which may arise in my child's self administration of these items and/or medications.

Physician/Healthcare Provider Signature: _____

LICENSE# STAMP

Parent/Guardian Signature: _____ **Date:** _____