

Crestwood Country Day Camp
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AUTHORIZATION FOR ADMINISTRATION OF OVER THE COUNTER (OTC) MEDICATIONS

Child's Name: _____ Birth Date: _____

Home Address: _____ Town: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

Dear Parents:

The following non-prescription medications are available and are used on an as-needed-basis to manage medical needs. New York State Law requires a written request from a physician indicating the use of such medications.

Please check off which medications may be given if needed:

Administer **ALL** over the counter medications listed below as needed

Select one:

Administer **ONLY** the medications checked below

- ___ Acetaminophen (Tylenol)
- ___ Anbesol/Orajel
- ___ Antihistimine/Allergy Medicine (Claritin/Actifed)
- ___ Antiemetic for nausea/motion sickness (Dramamine)
- ___ Antibiotic Cream (Neosporin)
- ___ Eyedrops (Visine/Murine)
- ___ Bismuth Subsalicylate for diarrhea (Pepto-Bismol)
- ___ Calamine Lotion Aloe/Sunscreen/Solarcaine
- ___ Dextromethorphan/Guaifenesin (Robitussin DM)
- ___ Diphenhydramine(Benadryl)
- ___ Generic Cough Drops
- ___ Hydrocortisone Cream
- ___ Ibuprophen (Advil/Motrin)
- ___ Imodium
- ___ Laxatives for constipation (Ex-Lax/ Milk of Magnesia)
- ___ Midol/Pamprin for menstrual cramps
- ___ Muscle rub (Bengay)
- ___ Phenylephrine Decongestant (Sudafed PE)
- ___ Sore Throat Spray (OTC)
- ___ Swimmers Ear Drops (OTC)
- ___ Tums
- ___ Lactaid Tablets (Generic OTC)

Parent/Guardian Signature

Date

Physician Signature

Physician Stamp