



CAMPER First Name _____ Last Name _____

Date of Birth _____

2025 CAMPER MEDICATION FORM (Front & Back)

REQUIRED FOR EVERY REGISTERED CAMPER

TO BE COMPLETED AND SIGNED BY MEDICAL PROVIDER (MD, PA, or NP)

As Needed Over-the-Counter Medication Permission:

Overnight camps carry a small stock of typical over-the-counter medications that may be administered during their stay only with a **medical provider's written approval and signature**.
 Stock medications include: FDA-approved sunscreen, insect repellent, Vaseline, triple-antibiotic ointment (generic for Neosporin), ibuprofen (generic for Advil), acetaminophen (generic for Tylenol), diphenhydramine (generic for Benadryl), hydrocortisone .05%, calamine lotion, aloe as sunburn relief, and saline solution.

<input type="checkbox"/> YES	Yes, I give approval for the above-named over-the-counter medications to be provided in reasonable dosages per direction on the original container for age and weight by designated YMCA camp staff.
<input type="checkbox"/> YES	WITH EXCEPTIONS. I give approval for the above-named over-the-counter medications to be provided in reasonable dosages per direction on the original container for age and weight by designated YMCA camp staff except for the following which may NOT be given:
<input type="checkbox"/> NO	No, the above named over the counter medications may not be provided to this camper. <i>(Medical provider signature still required)</i>

Prescription and Routine Medication Permission:

If a camper requires prescription and/or routine medication while at camp, the prescribing licensed medical provider must complete and sign the following section. These medications must be brought to camp by parent/guardian, in their original package or prescription bottle, with below signed orders. Medication will be administered at camp by qualified staff based on this written order and signature.

Medication Name	Route	Dosage	When to Administer

Licensed Medical Provider Information & Signature for authorization:

I hereby authorize the administration of designated medications for listed camper from qualified camp personnel.

Name Printed _____ Title _____

Signature _____ Date _____

Phone Contact _____ Lic # _____

Office Address _____

Use reverse side to list additional medications

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Medication Name	Route	Dosage	When to Administer

LICENSED MEDICAL PROVIDER SIGNATURE REQUIRED ON FRONT PAGE