Capital Guardian Youth
ChalleNGe Academy

www.cgyca.org

3201 Oak Hill Dr Laurel, MD 20724 phone 202-730-1579 fax 202-730-1532

OVER-THE-COUNTER MEDICATION ADMINISTRATION AUTHORIZATION FORM

This form must be completed fully and on file in the Infirmary in order for a camper to have formulary list OTC medication (see list below) provided by the camp during a camp day. A new and completed *OTC Medication Authorization Form* is required annually.

In order for non-prescription medication, not on the formulary list below, to be dispensed it must be provided by the parent/guarding in the unopened original container with the label intact. A *Medication Administration Authorization Form*, completed and signed by both a physician and a parent, must accompany the medication.

The Academy Nurse may call the prescriber, as allowed by HIPAA, if a question arises about the cadet and/or the cadet's medication(s).

PRESCRIBER'S AUTHORIZATION

CADET'S NAME	☐ MALE ☐ FEMALE	DATE OF BIRTH ___/___/___ Month Day Year
PARENT/GUARDIAN NAME		PHONE

PRESCRIBERS – Please indicate medications cadet may receive

Formulary List Medications	✓ Check here if permitted	Dose (if blank, as directed by package)	PRN for what symptoms	Relevant Side Effects/ Special Instructions
Acetaminophen Tablets 325 mg each	☐		Pain, Fever <100	
Ibuprofen Tab 200 mg each	☐		Pain, Fever <100, Inflammation	
Diphenhydramine HCl Tablets 25 mg each	☐		Itching, sneezing, congestion, allergic response	
Colace 100mg	☐		Constipation	
Tums	☐		Acid indigestion	
Pepto Bismol	☐		Mild nausea, mild diarrhea	
Hydrocortisone 1% cream	☐	Topical	Itching	
Triple Antibiotic Cream	☐	Topical	Cuts, scrapes	
Medicaine (Sting) Swabs	☐	Topical	Insect bites, itching	
Mentholyptic Cough Lozenges	☐		Coughing, sore throat	
Fexofenadine (Allegra)180 mg	☐		seasonal allergy symptons; runny nose, itchy eyes	
Melatonin 5mg	☐		unable to sleep	

12. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 14b below unless more restrictive dates are specified in 12a and 12b. This authorization is ***NOT TO EXCEED 1 YEAR***.	12a. FROM ___/___/___ Month Day Year	12b. TO ___/___/___ Month Day Year

13. PRESCRIBER'S NAME/TITLE			This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIPCODE	

14a. PRESCRIBER'S SIGNATURE *(Parent/guardian cannot sign here)*	14b. DATE

II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized academy nurse or staff member to administer the medication as prescribed by the above prescriber. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I authorize academy personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

15a. PARENT/GUARDIAN SIGNATURE	15b. DATE

15c. HOME PHONE #	15d. CELL PHONE #	15e. WORK PHONE #