



**PLEASE RETURN THIS FORM BY MAY 1<sup>st</sup> TO:**

**WINTER** (Until May 15th)

3 New King Street, White Plains, NY 10604  
p: 800-753-9118 f: 413-853-3030

**SUMMER** (After May 15th)

6 Hawthorne Road, Lenox, MA 01240  
p: 800-753-9118 f: 413-853-3030

## MEDICATION FORM

Please fill this form out for our Health Center, regardless if you have registered with KIDS MEDPACKS for distribution of your child's daily medications. As a reminder, all medications that are prescription medications must be registered with KIDS MEDPACKS for packaging through our pharmacy. If your son needs any over-the-counter medications while at camp, we will supply them for him.

Camper's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

### OVER-THE-COUNTER MEDICATION AUTHORIZATION:

I give permission for Camp Mah-Kee-Nac to administer over-the-counter medications to my son if the nurse deems it necessary. The following is a partial list of basic over-the-counter medications stocked in our Health Center so there is no need to send any of them to camp: Tylenol, Motrin, Pepto Bismol, Tums, Imodium AD, Mylanta, Imodium AD, Calamine Lotion / Anti-Itch Gel, Cortaid, Tinactin, Solarcaine, Benadryl, Sudafed, Robitussin, Robitussin DB and Dramamine.

Parent/Guardian signature to administer OTC medications \_\_\_\_\_

### DAILY AND PRN MEDICATION AUTHORIZATION: Check all that apply

- My child takes no daily medication
- My child takes daily medication, daily vitamins/nutritional supplements, and/or uses an inhaler and I have registered with KIDS MEDPACKS
- My child takes PRN (as needed) medication and I have registered with KIDS MEDPACKS (this includes inhalers, allergy medicine, ointments, nose sprays, eye drops, and liquids)

### SCHEDULE OF DAILY AND PRN(AS NEEDED) MEDICATIONS THAT WILL BE SUPPLIED BY KIDS MEDPACKS:

	Name of Medication	Dose	Frequency	<input type="checkbox"/> PRN	<input type="checkbox"/> Daily
Bkfst/Wake up: 8-9 AM	_____	_____	_____	<input type="checkbox"/> PRN	<input type="checkbox"/> Daily
	_____	_____	_____	<input type="checkbox"/> PRN	<input type="checkbox"/> Daily
	_____	_____	_____	<input type="checkbox"/> PRN	<input type="checkbox"/> Daily
Lunch: 12-1 PM	_____	_____	_____	<input type="checkbox"/> PRN	<input type="checkbox"/> Daily
	_____	_____	_____	<input type="checkbox"/> PRN	<input type="checkbox"/> Daily
	_____	_____	_____	<input type="checkbox"/> PRN	<input type="checkbox"/> Daily
Dinner: 6 PM	_____	_____	_____	<input type="checkbox"/> PRN	<input type="checkbox"/> Daily
	_____	_____	_____	<input type="checkbox"/> PRN	<input type="checkbox"/> Daily
	_____	_____	_____	<input type="checkbox"/> PRN	<input type="checkbox"/> Daily
Bedtime:	_____	_____	_____	<input type="checkbox"/> PRN	<input type="checkbox"/> Daily
	_____	_____	_____	<input type="checkbox"/> PRN	<input type="checkbox"/> Daily
	_____	_____	_____	<input type="checkbox"/> PRN	<input type="checkbox"/> Daily

Name of Prescribing Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address /City /State /Zip \_\_\_\_\_

I hereby authorize Camp Mah-Kee-Nac to administer the above listed medications to my child as directed.

**SIGNATURE OF PARENT OR GUARDIAN** \_\_\_\_\_