

# SOPHIA FAHS Medication Release Form

PHONE (516)429-5289, FAX (631)657-4714, EMAIL sophiafahs@gmail.com  
Sophia Fahs Camp c/o Allyson Barish, 19A Lone Oak Drive, Centerport, NY11721

**1) PARENT/GUARDIAN INSTRUCTION:** **This form, signed by your physician, is required for all campers.** Make sure you also sign below. If your child will be bringing any additional medications, including over-the-counter, homeopathic preparations, supplements, or vitamins, they must be listed and signed by a physician below. All treatments must be in original packaging and bottles, then placed in a zip-lock bag with the camper's name. All treatments must be turned into the nurse at registration. Any remaining will be returned to you at checkout. **NOTE: All medication in section A will be available at the Camp Infirmary. You must bring all medication listed in sections B and C.**

- 2) PHYSICIAN INSTRUCTION:**
- a. Section A: Unless indicated otherwise, all drugs listed will be administered at the discretion of the Camp Nurse. Please strike through any disallowed drugs, and comment as necessary.
  - b. Section B: Please complete for any OTC drugs (not listed in section A) that the camper will bring to camp.
  - c. Section C: Please complete for any RX drugs the camper will bring to camp.
  - d. Section D: Please complete for any further instructions.

**CAMPER NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **CAMPER WEIGHT:** \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**HEALTHCARE PROVIDER NAME:** \_\_\_\_\_ **LICENSE#:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**HEALTHCARE PROVIDER SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

*I recognize that this is a two-page document*

**HEALTHCARE PROVIDER STAMP:**

***By order of the NYS Department of Health, this form is required for all campers, and must be accompanied by proof of annual physical and immunizations.***

**SECTION A: OVER-THE-COUNTER MEDICATIONS AVAILABLE AT CAMP**

The following medications are available in the Camp Infirmary and will be administered as below, at the discretion of the Camp Nurses, unless crossed out or indicated otherwise below:

MEDICATION NAME	ROUTE	DOSAGE	SCHEDULE/INDICATION	COMMENTS
Advil	Oral (liquid, chewable tabs, and/or pills)	Per label instructions by age/weight	Every 6 hours as needed for pain or fever	
Benadryl	Oral (liquid, chewable tabs, and/or pills), Topical	Per label instructions by age/weight	Oral: every 4-6 hours as needed for allergic reaction Topical: as needed, no more than 3-4 times daily for allergic reaction	
Cepacol lozenges	Oral (liquid, chewable tabs, and/or pills)	Per label instructions by age/weight	Every 2 hours as needed for sore throat, no more than 4 doses in 24 hrs and no fever	
Imodium	Oral (liquid and/or pills)	Per label instructions by age/weight	As needed with each loose bm for simple diarrhea	

MEDICATION NAME	ROUTE	DOSAGE	SCHEDULE/INDICATION	COMMENTS
Robitussin DM	Oral liquid	Per label instructions by age/weight	Every 4 hours as needed for cough	
Tums	Oral tablets	Per label instructions by age/weight	As needed for upset stomach, not to exceed 7 tablets in 24 hrs	
Tylenol	Oral (liquid, chewable tabs, and/or pills)	Per label instructions by age/weight	Every 6 hours as needed for pain or fever	
Zyrtec	Oral (liquid, chewable tabs, and/or pills)	Per label instructions by age/weight	Once daily as needed for respiratory allergies	
Aloe Vera Gel	Topical	Per label instructions by age/weight	As needed for sunburn and other minor burns	
Burn cream with lidocaine	Topical	Per label instructions by age/weight	as needed, no more than 3-4 times daily for minor burns	
Calamine	Topical	Per label instructions by age/weight	As needed for itches, bites, skin irritations, rashes	
Hydrocortisone 2%	Topical	Per label instructions by age/weight	As needed for minor skin irritations and rashes, no more than 3-4 times daily	
Triple Antibiotic Cream/Ointment	Topical	Per label instructions by age/weight	As needed 1-3 times daily for cuts, scrapes and burns	

**SECTION B: ADDITIONAL OVER-THE-COUNTER DRUGS NOT PROVIDED BY CAMP: **MUST BE PROVIDED BY PARENT/GUARDIAN****

Please list below any over-the-counter medications being sent to camp by the parent/guardian as ordered by the camper's physician. This includes vitamins, supplements, homeopathic preparations, etc. All medications must be turned over the Camp Nurse during check-in.\*\* Use additional pages if needed.

MEDICATION NAME	ROUTE	DOSAGE	SCHEDULE/INDICATION	COMMENTS
**Sunscreen	Topical	Per label instructions	Daily, for protection from sun	
**Insect Repellant	Topical	Per label instructions	Daily, for protection from insects	

\*\* Will be stored with house parents, and applied daily. Please provide both for your camper.

**SECTION C: PRESCRIPTION MEDICATIONS**

Please complete with camper's current regimen for both scheduled and as-needed medications. All medications must be turned over the Camp Nurse during check-in. Use additional pages if needed.

MEDICATION NAME	ROUTE	DOSAGE	SCHEDULE/INDICATION	COMMENTS

**SECTION D: FURTHER INSTRUCTIONS**

Please list any further instructions, e.g. dressing changes, cast care, etc. Use additional pages if needed.

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