

# NON-PRESCRIPTION AUTHORIZATION FORM

**Parent & Physician must initial each approved non-prescription medication on line provided & write full signature on back page.**

Camper's Name \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_

**Acetaminophen:** tablets (i.e. Tylenol Regular Strength) 325 mg. ea.  
elixir (80 mg. per 1/2 tsp)

purpose: pain reliever/fever reducer

dosage: <110 lbs...1 tablets every 4-6 hours as needed; not to exceed 4 tablets in a 24 hour period

>110 lbs...2 tablets every 4-6 hours as needed; not to exceed 8 tablets in a 24 hour period

or Elixir ...60-71 lbs: 2 1/2 tsp...; 72-95 lbs: 3 tsp...every 4 hours as needed; not to exceed 5 doses in 24 hour period

Parent's Initials \_\_\_\_\_ Physician's Initials \_\_\_\_\_

**Ibuprofen** tablets (i.e. Advil) 200 mg. ea.  
oral suspension (i.e. Children's Advil) 100 mg. per tsp.

purpose: pain reliever/fever reducer

dosage: <110 lbs...1 tablet every 4-6 hrs.; not to exceed 4 tablets in 24 hr. pd.

>110 lbs...2 tablets every 4-6 hrs; not to exceed 4 tablets in 24 hr. pd.

for children 60-71 lbs: 2 1/2 tsp...72-95 lbs: 3tsp...every 6-8 hours as needed but no more than 4x a day

Parent's Initials \_\_\_\_\_ Physician's Initials \_\_\_\_\_

**Guaifenesin** syrup (i.e. Robitussin) 100 mg. per tsp.

purpose: loosens & relieves chest congestion

dosage: <110 lbs.....1 1/2 tsp every 4 hours

>110 lbs...3 tsp every 4 hours

Parent's Initials \_\_\_\_\_ Physician's Initials \_\_\_\_\_

**Pepto-Bismol** chewable tablets or liquid

purpose: relief for upset stomach, indigestion, nausea, heartburn, diarrhea

dosage: <110 lbs.....1 tablet (or 1 tbsp) every 1/2 to 1 hour as needed; max of 8 doses in 24 hr. pd.

>110 lbs...2 tablets (or 2 tbsp) every 1/2 to 1 hour as needed; max of 8 doses in 24 hr. pd.

Parent's Initials \_\_\_\_\_ Physician's Initials \_\_\_\_\_

**Mylanta** liquid

purpose: antacid-anti-gas

dosage: >110 lbs...shake well, take 3 tsps. between meals; not to exceed 24 tsps. in 24 hr. pd.

Parent's Initials \_\_\_\_\_ Physician's Initials \_\_\_\_\_

**Dramamine** chewable tablets 50 mg. ea.

purpose: motion sickness

dosage: <110 lbs...1 tablet every 6-8 hours, not to exceed 3 tablets in 24 hr. pd.

>110 lbs...2 tablets every 4-6 hours, not to exceed 8 tablets in 24 hr. pd.

Parent's Initials \_\_\_\_\_ Physician's Initials \_\_\_\_\_

TURN OVER

Camper's Name \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_

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**Pseudoephedrine HCL** tablets (i.e. Dimetapp) 120 mg. ea.

purpose: relieves nasal & sinus congestion due to colds & allergies  
dosage: >110 lbs...1 caplet every 12 hours not to exceed 2 caplets in 24 hrs.

Parent's Initials \_\_\_\_\_ Physician's Initials \_\_\_\_\_

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**Diphenhydramine HCL** (i.e. Benadryl) tablets 25 mg. ea.; liquid 12.5 mg. per tsp.

purpose: relief from allergic reactions i.e. stuffy, runny nose, sneezing, itchy, watery eyes, itchy throat  
dosage: <110 lbs...1 tsp. every 4-6 hrs.; do not take more than 6 doses in 24 hr. pd.  
>110 lbs...2 tsp liquid or 1 tablet every 4-6 hrs.; do not exceed 6 tablets (6 doses) in 24 hr. pd.

Parent's Initials \_\_\_\_\_ Physician's Initials \_\_\_\_\_

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**Immodium** caplets (each contains 2 mg loperamide HCL)

purpose: diarrhea  
dosage: <110 lbs...1 caplet after the first loose stool; 1/2 caplet after each subsequent loose stool; no more than 3 caplets in 24 hours  
>110 lbs...2 caplets after the first loose stool; 1 caplet after each subsequent loose stool; no more than 4 caplets in 24

Parent's Initials \_\_\_\_\_ Physician's Initials \_\_\_\_\_

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**Bacitracin ointment**

purpose: prevention of infection in minor cuts, scrapes, burns  
directions: apply small amount to affected area 1-3x daily

Parent's Initials \_\_\_\_\_ Physician's Initials \_\_\_\_\_

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**Caladryl lotion**

purpose: relief from poison ivy  
dosage: shake well; wash affected area; apply no more than 3-4x daily

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**Hydrocortisone cream 1%**

purpose: relief of itching from minor skin irritations, inflammation & rashes  
directions: apply to affected area no more than 3-4x daily

Parent's Initials \_\_\_\_\_ Physician's Initials \_\_\_\_\_

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## Parent & Physician full signature below:

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature & Title \_\_\_\_\_ Date \_\_\_\_\_

before June 15: JRT&SC PO Box 62H Scarsdale, NY 10583 914-668-3258 fax 914-723-4579  
after June 15: JRT&SC Kent School Kent, CT 06757 860-927-6339 fax 860-927-6340