Over-The- Counter Medication Authorization

Child's First and Last Name	Date of Birth:	Child's Age:

Super Senior___ Explorer____ Superteen____

Dear Parents/Guardians,

Occasionally while traveling, campers may require over-the-counter medications. The following over-the-counter medications, will be carried by the travel Director in their first aid kit. Please review the list below with your child and circle the medications that you would like the travel staff to assist your child in taking.

PARENT/GUARDIAN AUTHORIZATION FOR STAFF ADMINISTRATION

MEDICATION	**AILMENT**
Ibuprofen Midol Motrin Advil	Headache Pain Fever Swelling Menstrual Pains
Acetaminophen/Tylenol	Pain/Fever/Muscle Ache
Benadryl	Allergy/Antihistamine
Pepto Bismol/Kopectate Bismatrol	Upset Stomach Nausea
Dramamine	Motion Sickness

I give permission for Park Shore Country Day Camp TRAVEL STAFF member to assist my child in taking the medication I circled above in accordance to the proper dosage printed on the over-the-counter medication.

Parent/Guardian's Signature: ______________________

Print Name: ______________________________________

Primary Phone Number ___________________________