Dear Health Care Provider,

Pioneer Camp and Retreat Center, Inc. is required by the Erie County Health Department to have a signed Over the Counter Medication form and a Written Order for prescription medications on site for any child participating in our Summer Camp. Please fill out, sign this form and fax to 716-549-6018 or mail to Pioneer Camp, 9324 Lake Shore Rd. Angola, NY 14006. With out this form signed by the child's Health Care provider they are not allowed to be on site. We appreciate your cooperation in this matter.

Camper Name:_____ DOB:_____ Week Attending:_____

Complete this section for Over the Counter Medications

Each medication must be circled either "yes" or "no"

Yes	**No**	**Bactine** (topical) for minor wound care, first aid as needed
Yes	**No**	**Triple Antibiotic Ointment** (topical) for wound healing
Yes	**No**	**Tylenol** (oral) as directed on bottle for age/weight
Yes	**No**	**Ibuprofen** (oral) as directed on bottle for age/weight
Yes	**No**	**Chloraseptic Spray** for sore throat as needed
Yes	**No**	**Cough Drops** for coughing, minor throat irritation as needed
Yes	**No**	**Antacid Tablet** (oral) for stomach discomfort
Yes	**No**	**Miralax** (oral) laxative as directed on bottle for age/ weight
Yes	**No**	**Benadryl** (oral) for swelling, hives, allergic reaction as directed on bottle for age/weight
Yes	**No**	**Loratidine** (oral) for seasonal allergy symptoms, as directed on bottle for age/weight
Yes	**No**	**Calamine Lotion or Cortaid** (topical) for insect bites/ bee stings
Yes	**No**	**Visine/Murine Plus Eye Drops** (topical in eye) for minor eye irritation
Yes	**No**	**Sunscreen**
Yes	**No**	**Insect/Bug Repellent**
Yes	**No**	**Other** (Please describe)_____

Complete this section for Prescription Medications and PRN's

Medications: Please list *ALL* medications camper takes.

It is essential that we know if a camper is on any medications. Pioneer has nurses on site to dispense medications during their week here. All medications will be locked in the nurse's station. Campers may not carry any medication unless specific arrangements have been made by the camp nurse and parent or guardian of camper. **Medications MUST BE IN ORIGINAL PACKAGING (container with prescription label attached). Campers may not stay at Pioneer without current medications in the correct packaging, a completed and signed medical form and this form on site.**

Please list below each medication by name, dose, and frequency.

Medication	Route	Dose	Frequency	Comments	Date Written

If additional space is needed attach a separate sheet.

I hereby authorize that the indicated medications may be given to the above named child at Pioneer Camp and Retreat Center when necessary.

Physician's Name, Title:_____

Address:_____

City, State Zip:_____

Phone #:_____

License #:_____

Physician's Signature:_____

Date:_____