

**FORM G – OVER-THE-COUNTER MEDICATIONS**  
Return with Forms A, B, C, D, F

**THIS FORM REQUIRES PARENT/GUARDIAN'S SIGNATURE**  
**TO AUTHORIZE THE ADMINISTRATION**  
**OF ANY OVER-THE-COUNTER MEDICATIONS**

Camper's Name: Last \_\_\_\_\_ First \_\_\_\_\_

**I DO WISH OVER-THE-COUNTER MEDICATIONS TO BE GIVEN TO MY CHILD.**

I understand the Health Care Provider will administer the following over-the-counter medication or the generic version, if necessary, according to directions on the bottles unless a physician directs otherwise. The Camp provides over-the-counter medications.

**Sympton:**

**Over-The-Counter Medication:**

- Athletes Feet
- Skin irritations
- Minor aches/pain/fever
- Minor cough/sore throat
- Minor Allergic Reactions/Allergies
- Poison Ivy/Rashes
- Bug Bites
  
- Indigestion/Heartburn
- Constipation
- Clogged Ears
- Open Areas/Cuts

- Desenex
- Gold Bond Powder
- Tylenol/Advil/Ibuprofen
- Cough Drops/Chloraseptic Throat Spray
- Benadryl
- Calagel Lotion/Calamine Lotion
- Benzocaine Swabs/Dermoplast
- Hydrocortisone Cream/Benadryl Cream
- Antacid/Pepto Bismo/Tums
- Milk of Magnesia
- Auro-Dry
- Bacitracin

If any medication is not listed above, you must obtain a doctor's signature in order for the Camp Nurse to give said medication to your camper.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

Date: \_\_\_\_\_

Print Parent or Legal Guardian's Name \_\_\_\_\_

Parent's Home Telephone # or Cell Phone # \_\_\_\_\_

=====

I DO NOT WISH ANY MEDICATIONS TO BE GIVEN TO MY CHILD, \_\_\_\_\_  
Camper's Full Name

\_\_\_\_\_  
Signature of Parent or Legal Guardian

Date: \_\_\_\_\_

Print Name of Parent or Legal Guardian \_\_\_\_\_

Parent's Home Telephone # or Cell Phone # \_\_\_\_\_