Camper Name: _____ Date of Birth _____

Parent/Guardian Name: _____

The above named camper may receive the following medications at Longview Ministries, with dosage determined by label instructions for age/weight. **Provider circle Yes or No for each medication.**

Drug Name	Route	Schedule and Indications	Health Care Provider Order	Comments
Acetaminophen (Tylenol®)	PO (chewable tabs, elixir or tabs)	Q 4 hr prn for pain or fever >_____ °F	Yes No	
Ibuprofen (Advil®)	PO (chewable tabs, suspension, or tabs)	Q 6 hr prn for pain or fever >_____ °F	Yes No	
Guaifenesin (Robitussin ®, Mucinex®, etc.)	PO (syrup)	Q 4 hr prn for cough	Yes No	
Calcium Carbonate (Tums®)	PO (chewable tabs)	Up to 3 times a day prn for upset stomach	Yes No	
Diphenhydramine (Benadryl®)	PO (elixir, chewable tabs or pills)	Q 6 hr prn for allergic reaction symptoms (hives, insect bite)	Yes No	

The above named camper will also be receiving the following prescription medications while at camp.

Drug Name	Route	Dosage	Schedule and Indications	Health Care Provider Initials	Comments

Health Care Provider Signature: _____

Please copy form for any additional medications.