Confidential Over-The-Counter Medication Form

This form needs to be filled out, signed by a parent AND signed by a physician if you will allow the camp to give your child the selected medications. Please return this form by email (SSFS.Camp@ssfs.org), fax (301-830-6847), or postal mail (Camp Office, 16923 Norwood Road, Sandy Spring, MD 20860.)

Camper's full legal name/nickname: _____ ☐ Male ☐ Female

I ALLOW THE CAMP TO GIVE MY CHILD SELECTED MEDICATIONS

Parents/guardians may select over-the-counter medications by INITIALING beside the medication and signing below. Both parents and physician signatures are required by the state of Maryland for any of the following items listed below to be administered.

These medications may be administered to my child (parent/guardian initials are needed by EACH item):

_____ **Acetaminophen**
_____ **(Tylenol) Benadryl**
_____ **Benadryl Gel/Spray**
_____ **Caladryl Lotion**
_____ **Calamine Lotion**
_____ **Ibuprofen (Advil)**
_____ **Neosporin**
_____ **Throat lozenges/cough drops**

Refer to the Parent Handbook regarding the use of Sunscreen from the Office of Environmental Health and Food Protection.

I release the camp and its personnel of any liability related to the administration of the over-the-counter medication listed.

Parent's/Guardian's Signature: _____ Date: _____

There is no medical reason why the above camper should not receive the above initialed medications.

Physician's Name: _____

Physician's Signature: _____ Date: _____