FROST VALLEY YMCA
Wellness Center Health Form

STUDENT NAME: _____ **DATE OF BIRTH**: _____

PHYSICIAN'S NAME: _____ **PHONE**: _____

The following over-the-counter medications are available at the Wellness Center and can be administered as needed per label instructions by age and weight of the student. **PLEASE NOTE:** In accordance with New York State Education Law, Title 139, Section 6902, **absolutely NO over-the-counter or prescription medications, supplements, vitamins, or topical ointments can be administered without a physician and parent's signature.**

ALL MEDICATIONS SENT TO CAMP MUST BE SENT IN THEIR ORIGINAL CONTAINERS WITH LABELING INTACT

TO THE PROVIDER: Please, indicate approval for administration by circling yes or no in the space indicated.

MEDICATION	ROUTE	DOSAGE	SCHEDULE & INDICATIONS	MAY BE ADMINISTERED
Tylenol (Acetaminophen)	By mouth (elixir or tablets)	Per label instructions by age and weight	Every 4 hours PRN pain or fever > ____ºF	☐ Yes ☐ No
Motrin (Ibuprofen)	By mouth (elixir, suspension, or tablets)	Per label instructions by age and weight	Every 4 hours PRN pain or fever > ____ºF	☐ Yes ☐ No
Phenylephrine HCl	By mouth (tablets)	Per label instructions by age and weight	Every 4 hours PRN nasal congestion	☐ Yes ☐ No
Robitussin (Guaifenesin)	By mouth (syrup)	Per label instructions	Every 4 hours PRN cough	☐ Yes ☐ No
Dramamine (Diphenhydramine)	By mouth (chewable tabs or tablets)	Per label instructions by age and weight	Every 6 hours PRN motion sickness	☐ Yes ☐ No
Benadryl (Diphenhydramine)	By mouth (elixir, tablets, or capsules) apply topically	Per label instructions by age and weight	Every 6 hours PRN allergies, or insect bites	☐ Yes ☐ No
Claritin (Loratadine)	By mouth (tablets)	10 mg	Daily PRN allergy symptoms	☐ Yes ☐ No
Zyrtec (Cetirizine HCl)	By mouth (tablets)	10 mg	Daily PRN allergy symptoms	☐ Yes ☐ No
Allegra (Fexofenadine)	By mouth (tablets)	180 mg	Daily PRN allergy symptoms	☐ Yes ☐ No
Tums (Calcium Carbonate)	By mouth (tablets)	840 mg	Every 2 hours PRN acid indigestion	☐ Yes ☐ No
Imodium	By mouth (tabs or capsules)	Per label instructions	After loose stools	☐ Yes ☐ No
Lactaid (Lactase)	By mouth (caplets)	Three caplets	With first bite of dairy	☐ Yes ☐ No
Maalox	By mouth (suspension)	10 mg	Every 4 hours PRN upset stomach	☐ Yes ☐ No
Sunblock or Sunscreen	Apply topically	SPF ≥ 30	Apply PRN prior to sun exposure	☐ Yes ☐ No
Insect Repellant	Apply topically	Aerosol or pump	Per label instructions	☐ Yes ☐ No
Bacitracin Ointment	Apply topically	Bacitracin Zinc 500 U	Apply 1-3x Daily PRN minor cuts	☐ Yes ☐ No
Hydrocortisone Cream 1%	Apply topically	Hydrocortisone 1%	Apply 3-4x Daily PRN skin irritation	☐ Yes ☐ No
Antifungal Cream	Apply topically	Tolnaftate 1%	Apply twice daily to soothe itching	☐ Yes ☐ No
Calamine Lotion	Apply topically	Per label instructions	As needed PRN itching	☐ Yes ☐ No

ALLERGIES (food or drug): _____

PROVIDER: Please document the current medication regimen for the above-stated student, including scheduled and PRN medications in the space provided below.

MEDICATION	ROUTE	DOSAGE	SCHEDULE	COMMENTS

The above-stated student may self-carry the following items and/or medications (select all that apply):

☐ Sunblock ☐ Epi-Pen ☐ Albuterol Inhaler ☐ Proventil Inhaler ☐ Insulin Pump/Pens

The above noted "self-carry" items/medications are permitted for the indicated minor at all times. He/she/they have been instructed by the physician and acknowledges the proper understanding of the purpose, frequency, and appropriate method of use of these items and/or medications. As I consider him/her/them responsible, I will not hold Frost Valley YMCA personnel responsible for any errors which may arise in my child's self-administration of these items and/or medications.

Physician/Healthcare Provider Signature _____

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

LICENSE # STAMP

ADDRESS 2000 Frost Valley Rd, Claryville, NY 12725 **TEL** 845-985-2291 x 225 **FAX** 845-985-0059