REQUIRED NON-PRESCRIPTION MEDICINE CARD

NAME:____ **Session:** ❐1 ❐2 ❐FULL

GROUP: ❐TR ❐PIO ❐EXP ❐INT ❐LSR ❐USR ❐SSR

ALLERGIES (Non-Food):

Allergic to BEE STING? ❐YES ❐NO ❐NOT KNOWN

Allergic to MEDICATION(S)? ❐YES ❐NO ❐NOT KNOWN

If Yes, which medication(s)____

- **IMMUNIZATIONS UP TO DATE** (details required on Health Form): ❐YES ❐NO
- **DATE OF LAST TETANUS:** (M0NTH/YEAR)________________

In the event my child named above requires non-prescription medication while attending camp, I give permission for my child to receive from the camp nurse, as indicated and needed, the following non-prescription medication(s):

(Please CHECK and SIGN or we cannot administer ANY of these)

❐ANY LISTED BELOW - OR -

❐Advil (Ibuprofen)
❐Benadryl
❐Chlortrimeton
❐Dramamine, Non Drowsy
❐Kaopectate

❐Mylanta
❐Robitussin/Delsym
❐Sudafed
❐Tylenol
❐Claritin

Signed: ____**Date:**________________ **SUMMER** ____________

(Signature of Parent/Guardian)