A Tradition in Scout Camping at the Jersey Shore Since 1957, Celebrating 60 years!

Citta Scout Reservation
Over the Counter Medication Information

Camper's Name: _____ Troop Number: _____ Age:_____

The Citta Scout Reservation Health Officer has the following over the counter medications available for your scout should he need any. This form indicates which medication(s) you will allow our Health Officer to dispense should the event arise. **Please initial** the medications you give permission for our Health Officer to dispense to your child by completing **Option A**. If you do **NOT** wish for your child to be given any over the counter medications during his stay, please indicate that below by completing **Option B**.

Name of Medication	Possible Reasons for Administration	Initial of Parent/Guardian
Tylenol, Regular Strength	By mouth, for pain as needed, per weight/age every 4-6 hours	
Tylenol, Chewable	By mouth, for pain as needed, per weight/age every 4-6 hours	
Tylenol, Cold	By mouth, for pain as needed, per weight/age every 4-6 hours	
Pepto-Bismol	By mouth, for upset stomach, diarrhea as needed, per weight age	
Benadryl Allergy (liquid and tablets)	By mouth, for rash/itch/allergic reaction, per weight/age, 4-6 hrs	
Sudafed	By mouth, for Nasal congestion, per weight/age, every 6 hours	
Robotussin	By mouth, per weight/age, for cough as needed every 6 hours	
Chloraseptic Lozenges	By mouth, for sore throat or cough as needed	
Children's Claritin (liquid and tablets)	By mouth, for allergies as needed, per weight/age	
Children's chewable ibuprofen	By mouth, for pain as needed, per weight/age every 6-8 hours	
Children's Tums	By mouth, for upset stomach, per weight/age	
Ibuprofen, regular strength	By mouth, for pain as needed, per weight/age every 6-8 hours	
Antibiotic ointment	Topically, for wound care/prevent of infection, as needed	
Benadryl ointment	Topically, for itch/contact dermatitis as needed	
Calamine lotion	Topically, for itch/contact dermatitis as needed	
Hydrocortisone lotion	Topically, for itch/contact dermatitis as needed	
Mucinex	By mouth, for cough and phlegm, as needed every 12 hours	

Option A: Allow Meds as Needed

As parent or legal guardian of the above named child, **I give the Health Officer permission** to administer the medications that I have initialed. I understand that if I have NOT initialed the item, the Health Officer will not be able to administer any medications.
Date:_____ Parent/Guardian Signature:_____

Option B: No Over the Counter Medication Permitted

As parent or legal guardian of the above named child **I do NOT want the Health Officer to administer** any over the counter medications. In the event my child needs one of the medications listed, the Health Officer should contact me.
Please Provide Contact Information:

Parent/Guardian: _____ Telephone Number: _____

Date:_____ Parent/Guardian Signature: _____