

MEDICAL CARE FORM & Over the Counter Medication Opt Out

Student Name _____ Date of Birth _____

PERMISSION FOR MEDICAL CARE

I hereby grant permission to the Director of LJC, or his designee, to secure appropriate routine or emergency medical treatment for my child while attending LJC. I give the LJC medical staff permission to administer any over the counter medication approved by the covering physician as stated in our policy and procedure for standing orders.

Parent/Guardian Signature: _____ Date: _____

OVER THE COUNTER MEDICATION AND OPT OUT

It is assumed that the Litchfield Jazz Camp can administer all of the following over the counter medications as outlined in our standing orders and approved by our camp doctor. **To OPT OUT** of the administration of any of these medications please initial next to the medicine below. **If all of these medications are approved please sign the bottom.**

Medication Name	OPT OUT (Initial in box)	Medication Name	OPT OUT (Initial in box)
Allegra		Imodium	
Aloe Gel		Lactaid	
Auralgan (Ear drops)		Melatonin	
Bacitracin (Ointment)		Mylanta	
Benadryl		Miconazole (anti fungal spray)	
Caladryl lotion		Milk of Magnesia	
Cepacol Lozenges		Oragel (tooth ache gel)	
Claritin		Prune Juice	
Colace		Robitussin DM	
Ear Drops (homeopathic)		Solarcaine	
Emetrol (Nausea relief)		TUMS	
Dayquil Cold + Flue		Tylenol	
Hydrocortisone (Cream)		Vaseline	
Ibuprofen (Advil)		Zyrtec	

Parent / Guardian Signature _____ Date _____

INSURANCE INFORMATION

Policy Holder's Name: _____

Insurance vendor/provider/company: _____

ID Number: _____ Group Number: _____

PLEASE MAKE SURE YOUR EMERGENCY CONTACTS ARE UP TO DATE