

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		Melatonin	
Aloe Gel		Maalox	
Auralgan (Ear drops)		Miconazole (anti fungal spray)	
Bacitracin (Ointment)		Milk of Magnesia	
Benadryl		New Skin (ointment)	
Caladryl lotion		Oragel (tooth ache gel)	
Cepacol		Prune Juice	
Claritin		Robitussin DM	
Colace		Solarcaine	
Ear Drops (homeopathic)		Sudafed PE	
Dayquil		TUMS	
Hydrocortisone (Cream)		Tylenol	
Hydrogen Peroxide		Vaseline	
Ibuprofen (Advil)		Vicks Inhalation	
Imodium		Visine	
Lactaid		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