COOPERSTOWN ALL STAR VILLAGE
MEDICATION SHEET

Form Must Be Completed and Mailed with Final Payment. To:
Cooperstown All Star Village
PO Box 670
Cooperstown, NY 13326

INDIVIDUAL ORDERS FOR:

Name:_____ **DOB:**_____ **Weight:**_____

Team Name: _____ **Coach:** _____

Standard Over the Counter/PRN Medications (The following medications are available in the Infirmary and will be administered at the discretion of an RN or LPN if approval is indicated by the camper's healthcare provider.) Any other over the counter medications the child routinely takes and will be bringing with them must be added to this list.

DRUG NAME	ROUTE PLEASE CIRCLE PREFERRED FORMULATION	DOSAGE	SCHEDULE AND INDICATIONS	CAMPER HEALTHCARE PROVIDER ORDER	COMMENTS
Ibuprofen	Oral	200 mg		YES NO	
Acetaminophen	Oral	325 mg		YES NO	
Acetaminophen	Chewable	160 mg		YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	

Prescription Medications (Must complete with patient's current regimen for both scheduled and PRN medications use 2nd page if needed)

DRUG	ROUTE	DOSAGE	SCHEDULE & INDICATIONS	COMMENTS

Camper's Health Care Provider (MD, NP, PA) Name:_____ Phone_____

Address:_____ License#_____

Signature:_____ Date:_____