Camper Name: _____ DOB: _____

STANDARD OVER THE COUNTER/ PRN MEDICATIONS – *PROVIDER SIGNATURE REQUIRED*

(Medication is available in the infirmary/ First Aid Kit; to be administered at the discretion of the RN/ PNP)

THIS SECTION MUST BE COMPLETED, EVEN IF THE CHILD IS NOT ON ANY MEDICATIONS. This must be signed by MD/NP or your child will NOT be able to receive OTC medications at Camp, should a need arise.

PARENT/GUARDIAN DIRECTIONS- Please **sign** before dropping off at the provider's office.

HEALTH CARE PROVIDER DIRECTIONS: Please circle "yes" or "no" in the provider order column and **sign below**.

DRUG	ROUTE {please circle preferred formulation(s)}	DOSAGE	SCHEDULE	PROVIDER ORDER	COMMENTS
Tylenol	PO (chewable tabs, elixir, or tabs)	Per label instructions by age / weight	Q 4 hr prn for pain or fever >	Yes / No	
Ibuprofen	PO (chewable tabs, suspension, or tabs)	Per label instructions by age / weight	Q 6 hr prn for pain or fever >_____	Yes / No	
Robitussin	PO (syrup)	Per label instructions by age / weight	Q 4 hr prn for cough	Yes / No	
Pepto-Bismol	PO (liquid, or chewable tabs)	Per label instructions by age / weight	Q 30 min to 1 hour prn for diarrhea (no>8 doses/24 hr)	Yes / No	
Dimetapp	PO (elixir or tabs)	Per label instructions by age / weight	Q 6 - 8 hr prn for nasal congestion / drainage	Yes / No	
Benadryl	PO or Topical (elixir, chewables, pills or topical)	Per label instructions by age / weight	Q 6 hr prn for allergic reaction (hives, insect bite)	Yes / No	
Lotions or Spray (Neosporin, Calamine, Hydrocortisone, etc)		Per label		Yes / No	
Eye Drops		Per label		Yes / No	
Cough Drops		Per label		Yes / No	

Signatures Required:

Provider Signature: _____ Date: _____

Provider Name (Print): _____ Institute/ Hospital: _____

License #: _____

Parent/ Guardian Signature: _____ Date: _____

Parent/ Guardian Name: _____ Phone: _____

Camper Name: _____ DOB: _____

ALL PRESCRIPTION Medications and Additional Over the Counter Medications
PROVIDER SIGNATURE REQUIRED

Nurses will use this form to review protocols and ensure that all medications and proper administration procedures are followed at camp. Our medical staff will call if there are any questions/ discrepancies when they are preparing medication to clarify or if a medication was not sent that is listed on the form.

Please complete with patient's current regimen for both **scheduled and prn medications,** including heparin flushes for central lines. **Please also include any medication the child routinely takes, including vitamins and natural remedies.** If applicable, include any epi-pens or inhalers.

PARENTS/GUARDIANS - Please note that you are responsible for sending these medications to camp with your child. If the child takes a prescribed medication by a psychiatrist, please note their primary provider may require you to have the psychiatrist sign off on order. In that case, you may use two copies of this form.

☐ Child Takes **NO** Prescribed/ Additional Over the Counter Medications

Drug Name	Dose (mg)	Time taken	Reason	Parent Initial	MD/NP Initials

Additional Orders: (as deemed necessary by health care provider to be implemented by a RN/NP (i.e. blood draws / lab work, dressing changes, case care, feeds via G-tube, etc.)

_____

_____

Signatures Required:

Provider Signature: _____ Date: _____

Provider Name (Print): _____ Institute/ Hospital: _____

License #: _____ Phone #: _____

NOTE: If Camper has changes after completion of this form, please request a Late Changes form.

Camp Good Days Phone: (716) 206-0709 Fax: (716) 206-0712

Camper Name: _____ DOB: _____

HEALTH INFORMATION / PHYSICAL EXAM – *PROVIDER SIGNATURE REQUIRED*

Campers are required to have had a physical exam in the last year. Please complete the form below or send copy of last physical and immunization records. School forms that do not include review of systems will **NOT** be accepted.

Date of Exam (within 1 year): _____

Vaccine	Date		Date		Date		Date	
Varicella	#1		#2		Chicken Pox Disease:			
MMR	#1		#2		Measles Disease:			
DTAP	#1		#2		#3		#4	
Tdap	#1		#2					
Polio	#1		#2		#3		#4	
Hib	#1		#2		#3		#4	
Hepatitis A	#1		#2					
Hepatitis B	#1		#2		#3			
Pneumococcal	#1		#2		#3		#4	
Meningococcal	#1		#2		#3			
COVID-19 (indicate type)	#1		#2		#3		#4	
Last influenza								

Height/ Weight		General Development	
Vitals (T, P, R, BP)		Skin	
H.E.E.N.T.		Abdomen	
Heart		GU	
Lymph		Musculo-skeletal	
Lung		Neurologic	

SIGNIFICANT MEDICAL HISTORY:

Medical Conditions/ Concerns (i.e. asthma, diabetes, seizure, etc.)

Allergies (medication, food, or environmental): ☐ No ☐ Yes Explain:

Food Restrictions: ☐ No ☐ Yes Explain:

Physical Restrictions or Limitations: (casted/ splinted limb, vision/ hearing deficits, mobility issues, etc.)

Signatures Required:

Provider Signature: _____ Date: _____

Provider Name (Print): _____