CAMP ONYAHSA PHYSICIAN CAMP AUTHORIZATION FORM Physicians/health care providers, please review and complete this page and the following page. Attach additional information if needed. **Parent/guardian AND physician signatures are required at the bottom of this page.**

Camper's Name:_____ **Birth Date** _____ **Age:** _____ ☐ **Male** ☐ **Female**

Today's date_____ **Physical Exam done today?** ☐Yes ☐No (**If "No", date of last physical:** _____/_____/_____)*
Month Day Year

* American Camp Association (ACA) accreditation standards specify physical exam within last 12 months.

Weight _____**lbs Height** _____**ft** _____**in Blood Pressure**_____/_____ **Pulse** _____ **BMI** _____ **Corrected Vision** _____ **Hearing** _____

The camper is undergoing treatment at this time for the following conditions: (describe below) ☐ None.

_____

_____

Diet/Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions (describe below)

_____

_____

Allergies: ☐ No known allergies. ☐ To foods: (list) ☐ To medications: (list) ☐ To the environment (insect stings, hay fever): (list) ☐ Other allergies (list) **Describe previous reactions to any allergies:**

_____

_____

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes
If you answered "Yes", what do you recommend? (describe below)

_____

_____

Other treatments/therapies to be continued at camp: (describe below) ☐ None needed.

_____

_____

Additional Orders: (peak flows, blood draws/lab work, dressing changes, cast care, feedings via GT, etc.) (describe below)

_____

_____

I have reviewed the Camper Health History and have discussed the camp program with the camper's parent(s)/guardian(s). Based on my knowledge of the camper's physical health and behavioral characteristics, in my position as his/her primary care physician, I deem that the camper is:

☐ **is able to participate in an active camp program** ☐ **is <u>not</u> able to participate in an active camp program**

Physician's Signature_____ **Title**_____

Physician's Name Printed_____ **License #**_____

Office Address_____
Street Address City State Zip

Phone Number_____ **Fax Number**_____**Date**_____

I also give my permission for the medications indicated on page 8 to be given to my child if needed.

Signature of Parent/Guardian_____ **Date**_____

CAMP ONYAHSA PHYSICIAN CAMP AUTHORIZATION FORM For completion by physicians/health care providers.
CAMPER NAME:

PRESCRIBED MEDICATIONS BEING TAKEN ☐This camper will not take any daily medications while attending camp.
☐This camper will take the following prescribed medication(s) while at camp.

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. Please list **ALL** medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

Name of Prescription Drug/ Medication	Date Started	Reason for Taking	When it is given	Amt or Dose given	How it is given
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		

PHYSICIANS INDIVIDUAL ORDERS FOR OVER-THE-COUNTER MEDICATIONS This information is required for all resident camps by the State of New York. The following medications or their generic equivalents may be available in the Health Center and will be administered at the discretion of the Camp Health Director, if prior written approval is hereby indicated by the participant's primary health care provider.
****All medication will be dispensed per directions on package and camper age/weight unless otherwise indicated by physician.**

Over the Counter Medication	Needed/Used to treat	Physician Permission	Amt or Dosage* (Leave blank if per package)	How it is given* (Leave blank if per package)
Acetaminophen (Tylenol)	Fever, headache, pain reliever	☐Yes ☐No		
Ibuprofen (Advil, Motrin)	Fever, headache, pain reliever	☐Yes ☐No		
Phenylephrine/psuedoephedrine decongestant (Sudafed & PE)	Nasal congestion	☐Yes ☐No		
Diphenhydramine antihistamine/ allergy medicine (Benadryl)	Allergies, allergic reactions, nasal congestion, insect bites	☐Yes ☐No		
Guaifenesin/dextromethorphan cough syrup (Robitussin & DM)	Cough	☐Yes ☐No		
Sore throat spray (Chloraseptic), throat lozenges	Sore throat	☐Yes ☐No		
Lice shampoo or cream (Nix)	Lice, nits	☐Yes ☐No		
Antibiotic cream/ointment	Wounds, cuts, abrasions	☐Yes ☐No		
Hydrocortisone cream	Insect bites, plant reactions	☐Yes ☐No		
Laxative (Milk of Magnesia)	Constipation	☐Yes ☐No		
Imodium AD, Kaopectate	Diarrhea	☐Yes ☐No		
Bismuth subsalicylate (Pepto Bismol), Tums, Maalox	Upset stomach	☐Yes ☐No		
Calamine lotion (Caladryl)	Insect bites, plant reactions	☐Yes ☐No		
Rubbing alcohol, peroxide	Wounds, cuts, abrasions	☐Yes ☐No		
Burn jel, Aloe, Lanacane	Burns, sunburn	☐Yes ☐No		

Please make sure BOTH physician and parent/guardian have signed Page 1. Thank you!