

***This form must be completed by your child's physician/health care provider and requires his/her signature in order for ANY (including over-the-counter, vitamins, supplements, etc.) medications to be given to your child while at camp.***

## Health Care Recommendations

### **GENERAL INFORMATION SECTION**

**Camper Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

I have examined the above camp participant. Date of Exam \_\_\_\_\_ BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant \_\_\_\_\_ is \_\_\_\_\_ is not able to participate in an active camp program.  
The applicant is under the care of a physician for the following conditions:

\_\_\_\_\_

Current treatments include: \_\_\_\_\_ Are these to be continued at camp? YES NO

\_\_\_\_\_

**Recommendations and restrictions at camp and additional information for camp Health Care Staff:**

\_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions? \_\_\_\_\_

Known allergies: \_\_\_\_\_

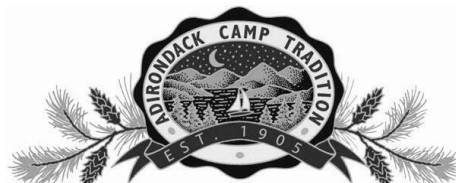
Describe any limitations or restrictions on camp activities. \_\_\_\_\_

**The medication portion on the back of this form requires your physician/health care providers signature and office stamp.**

**NO MEDICATION including prescription, OTC (over-the-counter) or PRN (whenever necessary such as Tylenol or Motrin) will be administered without a physician's signature.**

If you have any questions or concerns please email the health director at [kathygigs@verizon.net](mailto:kathygigs@verizon.net)  
(please write POKO camper in the subject line).

We look forward to caring for your child/children this summer,  
Kathy, Christa, Bobbi



**Pok-O-MacCready Camps**

P.O. Box 397  
Willsboro, NY 12996

## Medication Section

**No medications of any kind, including prescription and/or OTC substances (vitamins, fluoride, holistic supplements, etc.) can be given at camp *without each being listed and signed.***

*MEDICATIONS to be administered at camp:*

Drug Name	Dosage	Frequency	Route	Reason	Health Care Provider Signature for EACH

### **PRN MEDICATIONS stocked by the Health Office to be administered at camp:**

Drug Name	Dosage	Frequency	Route	Reason
Diphenhydramine HCL	6-12 yo 12.5 mg – 25 mg >12 yo 25 mg – 50 mg	Every 4-6 h PRN	PO	Pruritis or allergic reactions
Acetaminophen	15 mg/kg	Every 4 h PRN	PO	For T > 100° or discomfort
Ibuprofen	10 mg/kg	Every 6-8 h PRN	PO	For T > 100° or discomfort
Antifungal Cream		PRN	Topical	For Athlete's Foot/Jock Itch
Calamine Lotion		PRN	Topical	Poison Ivy / Poison Oak
Pseudoephedrine	6-12 yo 30 mg >12 yo 30-60 mg	Every 4-6 h PRN	PO	Nasal Congestion
Generic Tums	1-2 Tablets	Every 2-4 h PRN	PO	GI upset
Generic Robitussin DM	6-12 yo 100-200 mg >12 200-400 mg	Every 4 h PRN	PO	Cough
Antibiotic Ointment	To scrape or wound	PRN	Topical	To wound or skin irritation
Hydrocortisone Cream	1%	2-3 times daily	Topical	Skin irritation
Generic Cough Drops	1	PRN	PO	Simple cough or throat irritation

**Signature below indicates that all PRN medication may be administer by the camp RN after assessment. If a PRN medication above is not to be administered please cross off.**

Signature of Health Care Provider/Physician \_\_\_\_\_ Date \_\_\_\_\_

Health Care Provider Stamp