This form must be completed by your child's physician/health care provider in order for your child to attend camp. Physician/Health Care Provider Signature/Office Stamp REQUIRED on back of form.

Health Certificate/Medication Form
Health History Section

Camper Name: _____ **DOB:** _____

Physical Exam: Date of Exam_____ BP_____ Weight _____Height _____

□ Exam Within Normal Limits

□ Specify any abnormality_____

_____

_____

Significant Medical/Surgical History:

_____

_____

_____

If Asthma is listed please attach Asthma Treatment Plan

Allergies: □ LIFE THREATENING_____ (Attach Anaphylaxis Care Plan)

□ Food_____ □ Insect_____

□ Medication_____ □ Other_____

Recommendations/Restrictions:

Free from contagions & physically qualified for all camp activities: YES NO (Specify below)

Specify Restrictions_____

Any dietary restrictions or prescribed meal plan: NO YES (Specify below)

_____

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

<u>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.</u>

☐ Please check if camper has a severe, chronic developmental disability. If so please provide documentation about the diagnosis and mode of treatment and/or information about individual treatment, care or behavioral plans, if such plans are available (add additional pages if necessary).

_____

_____

If you have any questions or concerns please email Sarah at info@pokomac.com who will forward the email to the health director.

Please return form to:

Pok-O-MacCready Camps
P.O. Box 397
Willsboro, NY 12996

Make sure both sides of form are completed

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 below

Please make sure both sides of form are completed