Physician Form/Medication Form

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.

Pok-O-MacCready Camps is a traditional residential and day camp located in Willsboro, NY. Campers stay for a minimum of 2 weeks and will engage in activities including swimming, hiking, sports, creative arts, rock climbing, mountain biking, etc. Counselors are trained in basic first aid/CPR, and multiple RNs are on site at all times.

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)

_____

□ 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).

Make sure both sides of form are completed

Medication Section

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. **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

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

Drug Name	Dosage	Frequency	Route	Reason
Diphenhydramine HCL Antihistamine	6-12 yo 12.5 mg – 25 mg >12 yo 25 mg – 50 mg 10mg or 5mg	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 administered 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: