CAMPER HEALTH-CARE RECOMMENDATIONS
By LICENSED MEDICAL PERSONNEL

FORM 2

Adapted from form developed by American Camp Association, American Academy of Pediatrics Council on School Health & Association of Camp Nurses

Mail this form to:
Marion Schumacher
6 Soundview Drive North
Huntington, NY 11743
By May 31

***To Parent(s)/Guardian(s): Complete this section** and give **this form (FORM 2), the form labeled "Individualized Standing Orders"** and **a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1)** to your child's health-care provider for review.*

Dates will attend camp: from _____(Month/Day/Year) to _____(Month/Day/Year)

Camper Name: _____ (First) _____ (Middle) _____ (Last)

☐ Male ☐ Female Birth Date _____(Month/Day/Year) Age on arrival at camp _____

Camper home address: _____

_____ (City) _____ (State) _____ (Zip Code)

Custodial parent(s)/guardian(s) phone: (_____)_____ (_____)_____

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

***Medical Personnel**: Please do the following:*
1. ***Review the CAMPER HEALTH HISTORY FORM (FORM 1)***
2. ***Complete all remaining sections of this form (FORM 2).***
3. ***Complete the "Individualized Standing Orders."***
4. ***Attach additional information if needed.***

Physical exam done today: ☐ Yes ☐No (**If "No," date of last physical**: _____(Month/Day/Year))

Weight: _____ lbs Height: _____ft _____in Blood Pressure_____/_____

Allergies: ☐ No Known Allergies

☐ To foods ***(list):***

☐ To medications: ***(list):***

☐ To the environment ***(insect stings, hay fever, etc. – list):***

☐ Other allergies: ***(list):***

Describe previous reactions:

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

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

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

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes

If you answered "Yes" to the question above, what do you recommend? ***(describe below—please attach additional information if needed)***

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider (please print): _____Signature: _____Title: _____

Office Address_____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Telephone: (_____) _____ Date:_____

Camper Name _____ (First) _____ (Middle) _____ (Last) _____ (For Camp Use) Cabin or Group _____ (For Camp Use) Session _____

Camp Ma-He-Tu
Individualized Standing Orders

Name_____ DOB_____ Weight_____

Standard Over the Counter/PRN Medications - The following medications are available in the Health Care Center and will be administered at the discretion of a RN, **if approval** is indicated by the healthcare provider:

Drug Name	Route	Dosage	Schedule and Indications	Healthcare Provider Order and Initial	Comments
Acetaminophen (Tylenol)	PO (chewable tabs, elixir or tabs)	Per label instructions	Q 4 hr prn for pain or fever >101 °F, and colds	Yes No	
Ibuprofen (Motrin/Advil)	PO (chewable tabs, suspension or tabs)	Per label instructions	Q 6 hr prn for pain or fever >101 °F, and colds	Yes No	
Over the counter cold medicine with decongestant and cough suppressant	PO (syrup)	Per label instructions	Q 4 hr prn for cough	Yes No	
Chloraseptic spray	PO	Per label instructions	Sore throat	Yes No	
Over-the-counter throat lozenges	PO	Per label instructions	Sore throat	Yes No	
Milk of Magnesia	PO	Per label instructions	Constipation	Yes No	
Bismuth (Children's Pepto Bismol)	PO	Per label instructions	Indigestion or Nausea	Yes No	
Calcium Carbonate (Maalox/Rolaids/ Tums)	PO (chewable tabs)	Per label instructions	BID-TID prn for stomach upset	Yes No	
Topical Analgesic (Anbesol)	topical	Per label instructions	Toothache	Yes No	
Ear drying aid (Swimmers ear)	topical	Per label instructions	Suspicion of Swimmer's ear	Yes No	
Diphenhydramine (Benadryl)	PO (elixir, chewable tabs or pills)	Per label instructions	Q 4 - 6 hr prn for allergic reaction (itching, rash , swelling)	Yes No	
1% Hydrocortisone Cream / Ointment	topical	Per label instructions	Bee stings, insect bites, Poison Ivy, Poison Oak, Poison Sumac	Yes No	

Health Care Provider Name: _____ Phone # _____

Address: _____ License # _____

Signature: _____ Date: _____

Camp Ma-He-Tu
Individualized Standing Orders

Name_____ DOB_____ Weight_____

Drug Name	**Route**	**Dosage**	**Schedule and Indications**	Yes No Initial _____	**Comments**
Diphenhydramine cream/ointment (Benadryl Cream/ Ointment)	topical	Per label instructions	Bee stings, insect bites, Poison Ivy, Poison Oak, Poison Sumac	Yes No	
Calamine lotion (or generic)	topical	Per label instructions	Insect bites, Poison Ivy, Poison Oak, Poison Sumac	Yes No	
Over-the-Counter Pediculocide	topical	Per label instructions	Head lice	Yes No	
Analgesic balm (Mineral Ice)	topical	Per label instructions	Muscle aches and backaches	Yes No	
Hydrogen Peroxide	topical	Per label instructions	Wound cleansing	Yes No	
0.9 % Sodium chloride (Normal Saline/Saline Solution)	topical	Per label instructions	Wound cleansing, Eye irritation, Soak	Yes No	
Povidone Iodine swab	topical	Pre-packaged	Wound disinfectant	Yes No	
Antibacterial Ointment (Bacitracin)	topical	Per label instructions	Apply to abrasions, cuts, scratches and infections	Yes No	
Prescriptions Drugs:					
Additional Comments:					

Health Care Provider Name: _____ Phone # _____

Address: _____ License # _____

Signature: _____ Date: _____