

**STANDING ORDERS AND PHYSICIAN HEALTH EXAMINATION FORM**

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

**Birth Date:** \_\_\_\_\_

**THIS MUST BE COMPLETED BY A LICENSED PHYSICIAN:**

**Standing Orders: \*Must be current through entire stay at camp.**

**Attention Physician:** The following Over the Counter medications will be available in the site Health Center. Administration of these medications will be "per label directions" unless otherwise indicated. In all cases generic drugs may be used in place of name brands. A **PHYSICIAN** and **PARENT/GUARDIAN SIGNATURE** are required in order to allow the Site Medical Staff to administer **ANY** and **ALL** medications checked **YES**.

- |            |           |   |            |           |   |
|------------|-----------|---|------------|-----------|---|
| <b>Yes</b> | <b>No</b> |   | <b>Yes</b> | <b>No</b> |   |
| ___        | ___       | Acetaminophen: (discomfort/fever)               | ___        | ___       | Cortisone Cream: (topical, skin irritation) |
| ___        | ___       | Ibuprofen: (discomfort/fever, menstrual cramps) | ___        | ___       | Calamine Lotion: (topical, skin irritation) |
| ___        | ___       | Cepecol Lozenges: (throat irritation, cough)    | ___        | ___       | Ivarest Cream (skin irritation)             |
| ___        | ___       | Chloraseptic: (throat irritation)               | ___        | ___       | Visine: (eye irritation)                    |
| ___        | ___       | Benadryl: (allergies)                           | ___        | ___       | Imodium: (diarrhea)                         |
| ___        | ___       | Sudafed: (allergies/sinus)                      | ___        | ___       | Mylanta: (stomach discomfort)               |
| ___        | ___       | Claritin (allergies)                            | ___        | ___       | Tums: (heartburn/stomach discomfort)        |
| ___        | ___       | Bacitracin (antibiotic ointment)                | ___        | ___       | Milk of Magnesia: (constipation)            |

**ALL PRESCRIPTIONS AND ANY ADDITIONAL OVER THE COUNTER MEDICATIONS: (Attach sheets as necessary)**

Drug Name	Route	Dosage	Schedule	Comments directed by MD

Date of Standing Orders: _____	Phone _____	License # _____
Signature of Physician: _____		Printed Name _____

**Physical Examination: (determines fitness to engage in strenuous camping activities)**

The examination must be **less than 2 years before the end** of the child's time at camp. Please add extra comments on the reverse or add additional pages as necessary.

Height \_\_\_\_\_ Weight \_\_\_\_\_ B.P. \_\_\_\_\_ Allergies: (please specify) \_\_\_\_\_

General Appraisal: \_\_\_\_\_

Special Considerations: \_\_\_\_\_

Restrictions while attending camp: \_\_\_\_\_

I have examined the person herein described and it is my opinion that the camper/staff is physically able to engage in all camp activities, except as noted above.

Date of Physical Examination: _____	Phone _____	License # _____
Signature of Physician: _____		Printed Name _____

**Attention Parent/Guardian:**

MY CAMPER IS \_\_\_ IS NOT \_\_\_ AWARE OF WHAT MEDICATION SHE/HE WILL BE TAKING AT CAMP.

**\* MEDICATIONS MUST BE IN ORIGINAL CONTAINERS.\***

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name of Parent/Guardian:** \_\_\_\_\_