

COOPERSTOWN DREAMS PARK

Camper Examination and Medications

This form is to be completed by a Physician, Physician Assistant, or Nurse Practitioner

Doctor Examination or School Physical **Must Be COMPLETED within 12 months from the start of camp**

Last Name: First Name:

Team Name: Date Attending (from/to)

Medications Listed Here: *Dosing will be per label instructions by Age/Weight as needed*

New York State Department of Health requires that camps have an individualized set of standing orders for each camper attending. This list is for standard "Over the Counter" medications that campers may require while at camp. *These medications are available at the camp infirmary.* The medications will only be administered at the discretion of a Registered Professional Nurse.

A licensed health care provider needs to check the YES box if they wish the child to be eligible to receive the medication indicated.

Yes No	Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Acetaminophen (Tylenol)	<input type="checkbox"/> <input type="checkbox"/> Antibiotic Cream	<input type="checkbox"/> <input type="checkbox"/> Mylanta	<input type="checkbox"/> <input type="checkbox"/> Hydrocortisone 1% Cream
<input type="checkbox"/> <input type="checkbox"/> Ibuprofen (Advil)	<input type="checkbox"/> <input type="checkbox"/> Calamine Lotion	<input type="checkbox"/> <input type="checkbox"/> Zyrtec	<input type="checkbox"/> <input type="checkbox"/> Claritin
<input type="checkbox"/> <input type="checkbox"/> Diphenhydramine (Benadryl)	<input type="checkbox"/> <input type="checkbox"/> Antacids (Tums)	<input type="checkbox"/> <input type="checkbox"/> Dextromethorphan (cough syrup)	<input type="checkbox"/> <input type="checkbox"/> Other <input type="text"/>

All medications sent to camp must be in their original containers, including inhalers, which must come in their prescription labeled box

**** No pill boxes, or unlabeled containers will be accepted ****

Below, please list any Prescribed, or "Over-the-Counter" medications (not listed above), that the child will provide and take **WHILE AT CAMP**

Drug Name	Dosage	Route	Schedule / Indication	Comments
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

The camper is under the care of a physician for the following conditions:

Physician ordered treatments to be continued at camp:

Health Care Provider:

I have examined the person herein described and have reviewed his/her health history.
It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

Name: Phone:

Address: License #:

Provider Signature and Practice Stamp: Exam Date:

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