FORM #1 - PHYSICIAN'S EXAM

- **This form must be completed by a doctor**
- **Parent or guardian must sign this form**
- **Return this form no later than JUNE 9th**
- **Camper may not attend Camp without this form**

STANDING INDIVIDUALIZED ORDERS FOR: Camper's Name: _____

Prescription Medications: Please complete with patient's current regimen for both scheduled and PRN medications:

Drug Name	Route	Dosage	Schedule and Indications	Comments

Standard Over-The-Counter/PRN Medications: The following medications are available in the health cabin and will be administered at the discretion of the Camp Nurse, if approval is indicated by the camper's healthcare provider.
No response on this section will assume the answer is no.

Drug Name	Dosage	Schedule and Indications	Provider Order	Comments
Tylenol	Per label instructions by age/weight	Q 4 hr as needed for pain or fever > 100°F	❑Yes ❑No	
Ibuprofen	Per label instructions by age/weight	Q 6 hr as needed for pain or fever > 100° F	❑Yes ❑No	
Robitussin	Per label instructions by age/weight	Q 4 hr as needed for cough	❑Yes ❑No	
Pepto-Bismol	Per label instructions by age/weight	Q 30 min to 1 hr as needed for diarrhea (no>8 doses/24 hr)	❑Yes ❑No	
Mylanta	Per label instructions by age/weight	BID-TID as needed for stomach upset	❑Yes ❑No	
Dimetapp	Per label instructions by age/weight	Q 6-8 hr as needed for nasal congestion/drainage	❑Yes ❑No	
Benadryl	Per label instructions by age/weight	Q 6 hr as needed for allergic reaction (hives, insect bite)	❑Yes ❑No	
Calamine Lotion	Per label instructions	As needed for itching, bug bites and stings	❑Yes ❑No	
Bacitracin Ointment	Per label instructions	As needed for superficial wounds	❑Yes ❑No	
Hydrocortisome	Per label instructions	As needed for superficial swelling	❑Yes ❑No	

HEALTH CARE RECOMMENDATIONS BY LICENSED PHYSICIAN

DOB _____ Weight _____ Height _____ BP _____

In my opinion, the above camper/staff: ❑ is ❑ is not able to participate in an active camp program.

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

_____

_____

Any medically-prescribed meal plan or dietary restrictions: _____

_____

Known allergies to medication, food or other (insect stings, tree nuts, asthma, animals, etc.): _____

_____

_____

Description of any limitation or restriction on camp activities: _____

_____

_____

Date of last tetanus shot:_____ Are immunizations up to date? ❑ Yes ❑ No

The following section must be signed or stamped by a Health Care Provider.
Without this authorization your camper cannot be accepted into Camp Scully.
We strongly suggest keeping a copy of this form and bringing it to Camp with you.

HEALTH CARE PROVIDER AUTHORIZATION

(Parent/Guardian must also sign this box.)

Camper's Health Care Provider Name: _____

Address: _____ Phone: _____

Signature: _____ **License #: _____**

Date: _____

I have read the doctor's documentation in this form and I agree with the physician's individual medical orders for my child.

Signature of Parent/Guardian: _____ Date: _____

Return this form no later than June 9th to:
Camp Scully Registrar, PO Box 28, Rensselaer, NY 12144
Email: campscully@ccalbany.org
Telephone: 518-283-1617
Fax: 518-303-1484