MA-HE-TU

Registrar: (631) 351 - 1657
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ACCREDITED

Form 2: Camper Health Recommendations
(To be completed by Licensed Medical Professional)

Camper Name: _____ (Last Name) (First Name) (Middle Initial) Date of Birth: _____ (MM/DD/YY)

Physical Exam:
NYS Dept of Health requires a complete physical exam within 12 months of attending camp.

Date of Last Physical Exam: _____

Weight: _____ lbs. **Height:** _____ inches **HR:** _____ bpm **BP:** _____ /_____

Health Conditions:
Please describe any current conditions the camper is being treated for and if those treatments or therapies will need to be continued at camp:

☐ None

Restrictions:
Do you feel that the camper will require limitations or restrictions to activity while at camp?

☐ No ☐ Yes (Describe restrictions and recommendations below or include attachment)

Immunization History:
Attach a copy of the camper's immunization record. The following vaccines are required or strongly recommended (indicated by a *) to attend camp:

- Diphtheria, pertussis, and tetanus (DPT)
- MMR or Measles, Mumps and Rubella
- HiB – haemophilus influenzae type B
- Hepatitis B
- Varicella
- Poliomyelitis
- Meningococcal (MenACWY) for children over 11 y.o.*
- Covid-19*

Allergies:
☐ No Known Allergies
☐ Food (Specify):
☐ Medications (Specify):
☐ Environment (specify):
☐ Other (Specify):

If allergy noted, describe previous reactions. (Submit Emergency Action Plan, if applicable)

Does this camper require an EpiPen? ☐ Yes ☐ No

If Yes: ☐ EpiPen (0.3mg/0.3ml) IM ☐ EpiPen Jr (0.15mg/0.15ml) IM

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Camper Name: _____ Date of Birth: _____
(Last Name) (First Name) (Middle Initial) (MM/DD/YY)

Individualized Standing Orders (Non-Prescription Medications):

The following Non-Prescription Medications are available at the Camp Infirmary. NYS Law requires approval by a Licensed Health Care Professional (MD, DO, NP or PA) for these medications to be dispensed to the camper by the Camp RN when indicated. Parent permission is insufficient.

*Please approve the below medications by selecting "Yes" in the Healthcare Provider Order column and **initialing** next to each medication. For medications that should **not** be given, select "No" and provide any additional information.*

Medication Name	Route	Dosage & Schedule	Schedule & Indications	Healthcare Provider Order		Healthcare Provider Initial & Comments
Acetaminophen (Tylenol)	PO	Per label instructions	Pain or Fever	☐ Yes	☐ No	
Ibuprofen (Motrin/Advil) Naproxen (Aleve)	PO	Per label instructions	Pain or Fever	☐ Yes	☐ No	
Decongestant/cough suppressant/Mucolytic (Dayquil/Mucinex)	PO	Per label instructions	Cold Symptoms: Cough, congestion, sore throat.	☐ Yes	☐ No	
Lozenges (Cough Drop)	PO	Per label instructions	Sore throat	☐ Yes	☐ No	
Laxatives (Milk of Magnesia/MiraLAX)	PO	Per label instructions	Constipation	☐ Yes	☐ No	
Bismuth (Children's Pepto Bismol)	PO	Per label instructions	Indigestion, Nausea, Emesis	☐ Yes	☐ No	
Antacid: (Maalox/Tums/Mylanta)	PO	Per label instructions	Abdominal Upset	☐ Yes	☐ No	
Ear drying aid (Swimmers ear)	topical	Per label instructions	Suspicion of Swimmer's ear	☐ Yes	☐ No	
Antihistamine (Diphenhydramine/ Cetirizine/Fexofenadine/ Loratadine/Levocetirizine)	PO	Per label instructions	Allergic reaction (itching, rash, hives) Seasonal Allergy symptoms	☐ Yes	☐ No	
1% Hydrocortisone and/or Diphenhydramine 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 Pediculicide (Nix or generic)	topical	Per label instructions	Head lice	☐ Yes	☐ No	
Topical Analgesic (Mineral Ice/Salonpas)	topical	Per label instructions	Muscle aches and backaches	☐ Yes	☐ No	
Hydrogen Peroxide	topical	Per label instructions	Wound cleansing	☐ Yes	☐ No	
0.9 % Sodium chloride	topical	Per label instructions	Wound cleansing, Eye irritation, soak	☐ Yes	☐ No	
Povidone Iodine swab	topical	Pre-packaged	Wound disinfectant	☐ Yes	☐ No	
Antibacterial Ointment (Bacitracin/Triple Antibiotic)	topical	Per label instructions	Abrasions, cuts, scratches and infections	☐ Yes	☐ No	

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Health Recommendations
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Camper Name: ____
(Last Name) (First Name) (Middle Initial)

Date of Birth: ____________
(MM/DD/YY)

Camper Medications (to be completed by a Licensed Medical Professional)**:**

Please list ALL medications the camper will be required to take at camp. This includes over the counter/non-prescription medications, supplements, vitamins or ointments taken routinely or as needed (PRN).

☐ This camper will NOT take any daily medications, supplements, or vitamins while at camp.

☐ This camper will take the following daily medication(s), vitamins or supplements while at camp.

Prescription/Non-Prescription Medication, Supplement, Vitamin or Ointment	**Route (i.e. PO/IM, topical, etc)**	**Dose**	**Indication: (Please specify)**	**Schedule (Please follow camp administration times)**
				☐Breakfast (830-930am) ☐Lunch (1230-130pm) ☐Dinner (6-7pm) ☐Bedtime (930-1030pm) ☐As Needed (PRN) ☐Other:
				☐Breakfast (830-930am) ☐Lunch (1230-130pm) ☐Dinner (6-7pm) ☐Bedtime (930-1030pm) ☐As Needed (PRN) ☐Other:
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Provider Attestation: (Please complete)

I have reviewed the camper's health history and have discussed with the camper's parent/guardian. It is my opinion that the camper is physically and emotionally fit to participate in an active camp program.

Name of Provider (print): ________________________ License #: ________________________

Provider Signature: ________________________ Date: ________________________

Office Address: ____

Telephone: ________________________ Fax: ________________________