

Camper Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This **MUST** be completed by a licensed **PHYSICIAN** and is **REQUIRED** for camper **ATTENDANCE**.  
**Standing Orders Form must be filled out each year.**

**Attention Physician:** The following Over-the-Counter medications will be available in the Infirmary. Administration of these medications is “per label directions” unless otherwise noted. Generic drugs may be used in place of name brands. Please check “yes” for medications the Site Medical Staff is allowed to administer to the camper, as needed.

Yes	No	
_____	_____	Acetaminophen: (discomfort/fever, headache, pain relief)
_____	_____	Ibuprofen: (discomfort/fever, menstrual cramps, headache, muscle aches)
_____	_____	Hydrogen Peroxide/Antiseptic Solution (topical, wound cleaning)
_____	_____	Bacitracin/Neomycin/Polymyxin (topical, antibiotic ointment)
_____	_____	Calamine/Caladryl Lotion: (topical, skin irritation)
_____	_____	Hydrocortisone Cream: (topical, skin irritation)
_____	_____	Ivarest Cream (topical, skin irritation)
_____	_____	Cepecol Lozenges: (throat irritation, cough)
_____	_____	Chloraseptic: (throat irritation)
_____	_____	Robitussin: (cough suppressant, cough expectorant)
_____	_____	Visine: (eye irritation)
_____	_____	Benadryl: (topical for skin irritation, oral for allergies/allergy, cold symptoms)
_____	_____	Claritin (allergies/allergy symptoms)
_____	_____	Sudafed: (allergies/allergy symptoms, sinus, cold symptoms)
_____	_____	Imodium: (diarrhea, cramps, bloating)
_____	_____	Mylanta: (heartburn, acid indigestion, sour stomach, gas)
_____	_____	Tums: (heartburn, sour stomach, acid indigestion, upset stomach)
_____	_____	Pepto-Bismol: (nausea, heartburn, indigestion, upset stomach, diarrhea)
_____	_____	Milk of Magnesia: (constipation)
_____	_____	Sunscreen (to prevent overexposure to the sun; must be FDA approved)

**All PRESCRIPTION and any additional OVER-THE-COUNTER medications:** (Attach sheets as necessary)

Drug Name	Route	Dosage	Schedule	Comments directed by MD

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

A **PHYSICIAN** and a **PARENT/GUARDIAN SIGNATURE** are required by **NYS Dept. of Health** in order to allow the Site Medical Staff to administer **ANY** and **ALL** medications checked **YES**.

Date of Standing Orders: _____	Phone _____	License # _____
<b>Signature of PHYSICIAN:</b> _____		
Printed Name _____		

**Signature of PARENT/GUARDIAN:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

Upper New York Camp & Retreat Ministries thanks you for your cooperation.  
Please return all forms— to the site you will be attending first—at least three (3) weeks prior to arrival at camp.  
***A late fee of \$15 will be charged for health forms that are not received at least five (5) days prior to arrival***

**Upper New York Camp & Retreat Ministries – Physical Examination**

(Determines fitness to engage in strenuous camping activities)

The examination must be **within 12 months (1 year)** of the camper's **entire** stay/time at camp.

\*\* If there is a copy of a physical from the camper's Physician, Health Clinic, School or Sports Physical, please attach.\*\*

\*\*If no physical examination is attached, **PHYSICIAN** must complete this form for camper to attend camp session.\*\*

**Camper Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

B.P.: \_\_\_\_\_

Allergies: (please specify) \_\_\_\_\_

General Appraisal:

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Special Considerations:

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Restrictions while attending camp:

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Other:

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

Date of Physical Exam: \_\_\_\_\_ Phone \_\_\_\_\_ License # \_\_\_\_\_

**Signature of PHYSICIAN:** \_\_\_\_\_

Printed Name \_\_\_\_\_

I understand and agree to abide by any restrictions placed on my participation in camp activities.

**Signature of minor or adult camper:** \_\_\_\_\_ **Date** \_\_\_\_\_