Upper New York
CAMP & RETREAT
Ministries

STANDING ORDERS

NAME OF PARTICIPANT_____

DATE OF BIRTH_____ PROGRAM(S)_____

*The sections below **MUST** be completed by a licensed **PHYSICIAN** and is **REQUIRED** for participant **ATTENDANCE**.*
This Standing Orders form must be completed each year.

Attention Physician: The following non-prescription/over-the-counter medications may be stocked in the camp infirmary/health center. 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 participant, as needed.

☐ YES	☐ NO	Acetaminophen (discomfort/fever, headache, pain relief)
☐ YES	☐ NO	Ibuprofen (discomfort/fever, menstrual cramps, headache, muscle aches)
☐ YES	☐ NO	Hydrogen Peroxide/Antiseptic Solution (topical, wound cleaning)
☐ YES	☐ NO	Bacitracin/Neomycin/Polymyxin (topical, antibiotic ointment)
☐ YES	☐ NO	Calamine/Caladryl Lotion (topical, skin irritation)
☐ YES	☐ NO	Hydrocortisone Cream (topical, skin irritation)
☐ YES	☐ NO	Ivarest Cream (topical, skin irritation)
☐ YES	☐ NO	Cepecol Lozenges (throat irritation, cough)
☐ YES	☐ NO	Chloraseptic (throat irritation)
☐ YES	☐ NO	Robitussin (cough suppressant, cough expectorant)
☐ YES	☐ NO	Visine (eye irritation)
☐ YES	☐ NO	Benadryl (topical for skin irritation, oral for allergies/allergy, cold symptoms)
☐ YES	☐ NO	Claritin (allergies/allergy symptoms)
☐ YES	☐ NO	Sudafed (allergies/allergy symptoms, sinus, cold symptoms)
☐ YES	☐ NO	Imodium (diarrhea, cramps, bloating)
☐ YES	☐ NO	Mylanta (heartburn, acid indigestion, sour stomach, gas)
☐ YES	☐ NO	Tums (heartburn, sour stomach, acid indigestion, upset stomach)
☐ YES	☐ NO	Pepto-Bismol (nausea, heartburn, indigestion, upset stomach, diarrhea)
☐ YES	☐ NO	Milk of Magnesia (constipation)
☐ YES	☐ NO	Generic cough drops (throat irritation)
☐ YES	☐ NO	Lice shampoo or cream (for treatment of lice)
☐ YES	☐ NO	Sunscreen (to prevent overexposure to the sun; must be FDA approved)
☐ YES	☐ NO	Bug repellent (to prevent excessive exposure to bugs and ticks; must be FDA approved)

ALL PRESCRIPTION AND ANY ADDITIONAL OVER-THE-COUNTER MEDICATIONS *(attach additional sheets as necessary)*

Name of Medication	Dosage	Route (How it is given)	Schedule (When it is given)	Reason for taking it/ Comments directed by MD
			☐ Breakfast ☐ Mid-day Meal ☐ Evening Meal ☐ Bedtime ☐ Other:	
			☐ Breakfast ☐ Mid-day Meal ☐ Evening Meal ☐ Bedtime ☐ Other:	
			☐ Breakfast ☐ Mid-day Meal ☐ Evening Meal ☐ Bedtime ☐ Other:	

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

A PHYSICIAN and a PARENT/GUARDIAN SIGNATURE are required by New York State Department of Health in order to allow the Site Medical Staff to administer ANY and ALL medications checked "YES"

*Date of Standing Orders*_____ *Phone*_____ *License #*_____

*Signature of PHYSICIAN*_____

*Printed name*_____

Signature of custodial parent/guardian OR adult participant_____

Printed Name_____ Date_____

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.

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PHYSICAL EXAMINATION

NAME OF PARTICIPANT_____

DATE OF BIRTH_____ PROGRAM(S)_____

*The sections below **MUST** be completed by a licensed **PHYSICIAN** and is **REQUIRED** for participant **ATTENDANCE**.*
The examination must be ***within 12 months (1 year)*** of the participant'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.

EXAMINATION

Date of Physical Examination_____

Height_____ Weight_____ BP_____

General appraisal:

Known allergies (please specify):

Special Considerations:

Restrictions while attending camp:

Other

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 Signature*_____ *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 participant/camper_____ Date_____

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.