



**Standing Orders**

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

Office Use

Last Name, First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_

This **MUST** be completed by a **licensed PHYSICIAN** and is **REQUIRED** for Participant **ATTENDANCE**.

**Standing Orders Form must be filled out each year.**

**Attention Physician**: The Participant’s Over-the-Counter medications will be Administered “per label directions” unless otherwise noted. Generic drugs may be used in place of name brands.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **YES** |  | **NO** |  | Please check yes for medications Medical Staff can administer to the Participant |
|  |  |  |  | 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) |

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Drug Name** | **Route** | **Dosage** | **Schedule** | **Comments directed by MD** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

*Please Print*

Standing Orders Date: \_\_\_\_\_\_\_\_\_\_\_\_ **PHYSICIAN** Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN** Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please Print*

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

Parent/Guardian/Adult Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_





**Physical Examination:**

The Physical examination must be within 12 months (1 year) of the Participant’s entire stay at camp.

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

Office Use

Last Name, First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_

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

*Please Print*

Participant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_ B.P.: \_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_

General Appraisal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Special Considerations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Restrictions while attending camp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**PHYSICIAN’s** Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Participant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_