Upper New York Camp & Retreat Ministries – Standing Orders

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 # _____

Signature of PHYSICIAN: _____

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
Transforming Lives!

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:
_____

_____

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 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 _____**

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