



Physician's Individual Orders for Camp Participant:

Must be completed by the participant's health care provider (M.D.) to allow the administration of over the counter/as needed medication, and submitted to the Camp Office at least two weeks prior to the camper's attendance at Bethany Camp. **This is required for all resident camps by the State of New York.**

**Individual Orders for:**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Weight \_\_\_\_\_

**Standard Over the Counter/PRN Medications** (The following medications or their generic equivalents are available in the Bethany Camp Nurse's Office and will be administered at the discretion of the Camp Health Director, if prior written approval is hereby indicated by the participant's primary healthcare provider)

Drug Name (standard OTC or PRN name)	Dosage	Schedule and Indications	Camper Healthcare Provider Order/Permission	Comments
Robitussin		Cough	Yes No	
Benadryl or Sudafed		Nasal Congestion	Yes No	
Imodium AD		Diarrhea	Yes No	
Bactine or Benadryl		Insect Bites, Plant Reaction	Yes No	
Benadryl		Allergies	Yes No	
Acetaminophen or Ibuprofen		Headache	Yes No	
Pepto Bismol or Tums		Upset Stomach	Yes No	
Chloraseptic or Acetaminophen		Sore Throat	Yes No	
Ben Gay or Acetaminophen		Muscle Aches	Yes No	
Sine-Aid		Sinus Headache	Yes No	
Other			Yes No	

**Prescription Medications** (Health Care Provider, please complete with patient's current regimen for both scheduled and PRN medications).

Drug (Prescription Name)	Route	Dosage	Schedule and Indications	Comments

Camper's Health Care Provider: _____			
Phone _____	Fax _____	License # _____	
Address _____			
Street _____	City _____	State _____	Zip _____
Signature _____		Date _____	

**Additional Health Information** (Can be filled out by parent/guardian)

**Current special problems or conditions:** \_\_\_\_\_

**Allergies:** Bee Sting \_\_\_\_\_ Aspirin \_\_\_\_\_ Penicillin \_\_\_\_\_ Sulfa \_\_\_\_\_  
 Other: \_\_\_\_\_ Explain \_\_\_\_\_

**Bedwetter:** Yes No

**Immunization Record (This MUST Be Completed)**

Initial Dose: MMR \_\_\_\_\_ DTP \_\_\_\_\_ OPV \_\_\_\_\_ Tetanus \_\_\_\_\_  
 Last Booster: MMR \_\_\_\_\_ DTP \_\_\_\_\_ OPV \_\_\_\_\_ Tetanus \_\_\_\_\_

**Family Doctor:** \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Company** \_\_\_\_\_ **Policy Number** \_\_\_\_\_

Does your insurance require notification of provider? YES \_\_\_\_\_ NO \_\_\_\_\_

Under which parent's name is the insurance? \_\_\_\_\_

**In case of a medical emergency, I give consent for medical treatment which may include injection, anesthesia or surgery.**

**Signature of parent or guardian** \_\_\_\_\_