Flower City Work Camp Doctor Authorization

Your patient: ___________________________ DOB: _____________ is applying to attend a week of camp on their spring break in the Rochester area. There will be a medically trained staff at camp during the week to provide for any health care needs of all campers. In addition to the use of basic medical supplies to provide for general health care, the Camp Health Director is able to consult with an area M.D., P.A. or C.N.P. should the need arise. Your office and the camper's parents would also be contacted should the situation warrant. Please review the following general prn orders, deleting (by crossing out and initialing) or adding any additional OTC or prescription medications. Your signature at the bottom will authorize the Camp Health Director to administer treatment should your patient require general health care during his/her week at camp.

Orders for Camp Nursing Care

Seasonal Allergy Symptoms: Benadryl, Loratadine, Cetirizine per dosing instruction.

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Mild Pain: Tylenol or Ibuprofen per dosing instruction.

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Bee Sting WITH anaphylactic reaction (or ANY ANAPHYLACTIC REACTION):
Give epinephrine (bee sting kit) and call 911 immediately.

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Contact Dermatitis/Skin Allergies: Apply hydrocortisone cream per dosing instruction.

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ADDITIONAL PRN MEDICATIONS THAT MAY BE GIVEN:

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List all Allergies:
Medications __________________________________
Food __________________________________
Insect Stings __________________________________
Other __________________________________

List any food or activity restrictions:

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Camper's Name: ____

Please list ALL medications (including over the counter or nonprescription drugs) taken routinely.

Medication	Dosage	Specific Time Taken	Purpose

Attach additional pages for more medications.

☐ Camper must keep inhaler or epipen with them at all times (check if applies).
☐ Date of last physical exam: _________________
☐ Additional information that would be pertinent for the health staff at Flower City Work Camp____
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In my opinion, the above registrant is able to participate in an active camp program.

X____
In my opinion, the above registrant is able to participate in an active camp program.
*__Signature of Licensed Medical Personnel__ (MD, PA, or CNP ONLY)
*(*This signature is required for any camper or for any staff member under the age of 19. By signing this form, the MD, PA or CNP is indicating they have read all pages of this health form. An electronic signature is acceptable.)*

Date:
Printed Name of Physician: ____
Phone: _______________________
Professional Lic. Number: ____
Address: ____