Flower City Work Camp

2026 Required Medical Authorization Form

Camper Name _____ **Date of Birth** _____

Parent/Guardian: *Please* ***print*** *this form for your Health Care Provider to complete then* ***email*** *a scan or pictures of both pages to* ***medical@flowercityworkcamp.org*** ***no later than February 15, 2026*** *for review and approval.*

Health Care Provider: Please complete sections 1, 2, and 4 *regarding your patient's participation in Flower City Work Camp, a five-day sleep over camp in Rochester, NY involving sports, bending, and modest physical labor. At camp, there will be medically trained volunteers to support basic medical needs. The Camp Health Director will consult a local M.D., P.A. or N.P. as needed and contact your office and the camper's parents should the situation warrant. Your signature on this form authorizes the Camp Health Director to treat your patient should s/he require general health care during camp.*

SECTION 1: COMPLETED BY HEALTH CARE PROVIDER ONLY

Allergies

- ☐ Food allergy _____
- ☐ Medication Allergy _____
- ☐ Insect Sting/Bite Allergy _____
- ☐ Environmental/Other allergies _____

_____

Dietary Needs

- ☐ None
- ☐ Lactose Intolerant
- ☐ Gluten-Free
- ☐ Vegetarian
- ☐ Other (specify): _____

Health History and Restrictions

- ☐ Asthma _____
- ☐ Diabetes/blood sugar monitoring _____
- ☐ Seizure disorder _____
- ☐ Any recurrent/chronic illnesses _____
- ☐ Recent injury/surgery (past 12 months) _____
- ☐ Heart/Lung problems _____
- ☐ History of fainting/dizziness/Cardiac disease _____
- ☐ Emotional/behavioral/mental health concerns _____
- ☐ Problems with falling asleep/sleepwalking _____

Immunizations

Are immunizations current/up-to-date according to recommended schedules?

- ☐ Yes
- ☐ No; details: _____

Last Physical Exam

Date: _____ ***Must be within 12 months of first day of camp (March 30, 2026)***

- ☐ Patient was confirmed free of communicable disease during the exam.

Restrictions and Modifications

- ☐ Patient may participate in all camp activities including sports, bending, lifting, and modest physical labor, without restrictions.
- ☐ Patient has a condition(s) limiting full participation. Please describe limitations/restrictions and the necessary modifications below.

_____

_____

Camper Name _____
Date of Birth _____

SECTION 2: COMPLETED BY HEALTH CARE PROVIDER ONLY

Authorization To Administer Prescription Medications During Camp

Drug Name	Dose	Directions	Reason

Independent Use and Carry (Emergency medications only) I attest that this student has demonstrated to me that they can self-administer the medication(s) listed safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any Camp activity. Staff intervention and support is needed only during an emergency. **If yes, Health Care Provider please initial here:** _____

Prescription medications brought to camp must have actual prescription labels on them, including Epi-pens and inhalers for safety reasons. All non-prescription medications must be in new unopened bottles. Administration of over-the-counter medications will be "per label" directions for age/weight unless otherwise indicated by the healthcare provider.

SECTION 3: COMPLETED BY PARENT AND/OR HEALTH CARE PROVIDER

Authorization to Administer Over the Counter (OTC) Medications During Camp
Check here ❒ if ALL medications listed below are authorized.

Drug Name	Authorized	Drug Name	Authorized
Acetaminophen (fever/discomfort)	❒	Lotion, Aloe	❒
Bacitracin (antibiotic ointment)	❒	Tums (heartburn, stomach upset)	❒
Benadryl (allergies) or generic	❒	Vaseline (chapped lips, blisters)	❒
Cough Drops/Throat Lozenges	❒	Calamine Lotion	❒
Ibuprofen (fever/discomfort)	❒	Other:_____	❒

SECTION 4: REQUIRED SIGNATURES

PHYSICIAN/HEALTH CARE PROVIDER

Print Name: _____
Signature: _____
Phone number _____ Date _____
Professional Lic Number _____
Address _____

PARENT/GUARDIAN

Print Name: _____
Signature: _____
Phone number _____ Date _____