COOPERSTOWN DREAMS PARK

Camper Examination and Medications

This form is to be completed by a Physician, Physician Assistant, or Nurse Practitioner

**Doctor Examination or School Physical *Must Be COMPLETED* within 12 months from the start of camp **

Last Name: First Name:

Team Name: Week attending (from/to)

Medications Listed Here: ---------->

New York State Department of Health requires that camps have an individualized set of standing orders for each camper attending. This list is for standard "Over the Counter" medications that campers may require while at camp. The medications will only be administered at the discretion of a Registered Professional Nurse. **A licensed health care provider needs to check the YES box if they wish the child to be eligible to receive the medication indicated.**

Per Label Instructions by Age/Weight as needed

Yes	No		Yes	No	
☐	☐	Acetaminophen (Tylenol)	☐	☐	Antibiotic Cream
☐	☐	Ibuprofen (Advil)	☐	☐	Calamine Lotion
☐	☐	Diphenhydramine (Benadryl)	☐	☐	Antacids (Tums)
☐	☐	Mylanta	☐	☐	Hydrocortizone 1% Cream
☐	☐	Zyrtec	☐	☐	Claritin
☐	☐	Dextromethorphan (cough syrup)	☐	☐	

All medications sent to camp must be in their original containers, including inhalers, which must come in their prescription labeled box
**** No pill boxes, or unlabeled containers will be accepted ****

Below, please list the Over the Counter, Prescribed, and PRN medications the child will need *WHILE AT CAMP*

Drug Name	Dosage	Route	Schedule / Indication	Comments

The camper is under the care of a physician for the following conditions:

Physician ordered treatments to be continued at camp:

Health Care Provider:

☐ ***In my opinion, this camper is able to participate in an active camp program***

Name Phone

Address License #

Provider Signature and Practice Stamp

Exam Date:

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