



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 Camp Health Nurse 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. (The Camp Health Nurses meet all certification standards for Overnight Camps – He or she is typically an RN, but may be an EMT, LPN, MD, PA or CNP.)

Orders for Camp Nursing Care

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

Mild Pain: Tylenol or Ibuprofen per dosing instruction.

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

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

Stomach upset: Assess for dehydration, give clear liquids. Tums may be given for acid indigestion.

Fungal-type Skin infections: Apply Clotrimazole cream per dosing instruction.

Persistent Cough: Mucinex per dosing instruction.

ADDITIONAL PRN MEDICATIONS THAT MAY BE GIVEN:

MEDICATION RESTRICTIONS:

List all Allergies:

Medications _____

Food _____

Insect Stings _____

Other _____

List any food or activity restrictions:

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 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 _____

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 four pages of this health form. An electronic signature is acceptable.)

Date:

Printed Name of Physician: _____

Phone: _____

Professional Lic. Number: _____

Address: _____