# Flower City Work Camp Doctor Authorization

Your patient: _____ DOB: _____ is attending a christian outreach camp 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 days 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 |
|---|---|---|---|
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| | | | |
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| | | | |

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 this health form. An electronic signature is acceptable.)*

**Date:**
Printed Name of Physician: _____
Phone: _____
Professional Lic. Number: _____
Address: _____