Doctor's Orders Form

This form must be completed by the camper's health care provider ***in order to allow the administration of over the counter/as needed medication***, and submitted to the camp prior to the camper's attendance at Bethany Camp.

This is required for all resident camps in the state of New York.

Please fax the completed document to 716-287-2216, mail to Bethany Camp, 1633 Bates Rd., Sinclairville, NY 14782, or email to: office@bethanycamp.org

Individual Orders for:

Name: _____ DOB: _____ Weight: _____

Allergy Info

Allergies: Allergies requiring an epi-pen? Yes No Cause: _____

Other medical, emergency-based allergies: _____

Current Special Problems or conditions: _____

_____

OTC medication

The following medications or their generic equivalents are available in the Bethany Camp Nurse's Office and will be administered at the discretion of the Camp Health Director, if prior written approval is hereby indicated by the participant's primary healthcare provider.

Drug Name (Standard OTC or PRN name)	Dosage	Schedule and Indications	Camper Healthcare Provider Order/Permission	Comments
Triple Antibiotic/Neosporin		Open Wound	Yes No	
Robitussin		Cough	Yes No	
Benadryl or Sudafed		Nasal Congestion	Yes No	
Imodium AD		Diarrhea	Yes No	
Bactine or Benadryl		Insect Bites/Plant Reaction	Yes No	
Benadryl		Allergies	Yes No	
Acetaminophen or Ibuprofen		Headache	Yes No	
Pepto Bismol or Tums		Upset Stomach	Yes No	
Chloraseptic or Acetominaphen		Sore Throat	Yes No	
Ben Gay or Acetominaphen		Muscle Aches	Yes No	
Sine-Aid		Sinus Headache	Yes No	
Cough Drops		Cough Suppression	Yes No	
Calamine Lotion		Insect Bites	Yes No	
Itch Relief Stick		Insect Bites	Yes No	
Other			Yes No	

Doctor's Signature: _____

Date: _____

BETHANY Camp