DOCTOR'S ORDERS FORM!

Physician's Individual Orders for Camp Participant:

Must be completed by the participant's health care provider (M.D.) ***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 by the State of New York.** FAX TO 716-287-2216 or **online at www.bethanycamp.org**

Individual Orders for:

Name: ______________________________DOB: ____________ Weight__________

Standard Over the Counter/PRN Medications (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 Acetaminophen		Sore Throat	Yes No	
Ben Gay or Acetaminophen		Muscle Aches	Yes No	
Sine-Aid		Sinus Headache	Yes No	
Cough Drops		Cough Suppression	Yes No	
Calamine Lotion		Insect Bite	Yes No	
Other			Yes No	

Doctors Signature______________________________**Date**___/___/____

REQUIRED BY THE STATE OF NEW YORK!

Additional Health Information (Can be filled out by parent/guardian)

Current special problems or conditions:____

Allergies: Bee Sting__________ Aspirin___________ Penicillin__________ Sulfa_________
Other:________________ Explain______________

Bedwetter: Yes No

******Immunization Record (This MUST Be Completed, Or A Copy Attached)********

Initial Dose: MMR_________ DTP_________ OPV_________ Tetanus_________
Last Booster: MMR_________ DTP_________ OPV_________ Tetanus_________

******CAMPER'S CURRENT INSURANCE COVERAGE INFORMATION******

Insurance Company______________________________ **Policy Number**________________
Does your insurance require notification of provider? YES________ NO________
Under which parent's name is the insurance?_________________________________

In case of a medical emergency, I give consent for medical treatment which may include injection, anesthesia or surgery.

Signature of parent or guardian____