



Camper Prescription Medication Form

This form is to be filled out by the camper's pediatrician.
This form must be turned in along with medication
on the camper's first day at camp.

Camper Information

Name: _____ (Last) _____ (First)

Date of Birth: ____ / ____ / ____ **Age:** ____ **Sex (circle one):** Male Female
MM DD YYYY

Physical exam done today: Yes No (If "No," date of last physical: ____ / ____ / ____)
MM DD YYYY

ACA accreditation standards specify physical exam within last 24 months.

Weight ____ lbs Height: ____ ft ____ in Blood Pressure ____ / ____

Allergies: No Known Allergies

To foods (list): _____

To medications: (list): _____

To the environment (insect stings, hay fever, etc. (list): _____

Other allergies: (list): _____

Describe previous reactions: _____

Medication: This camper will not take any daily medications while attending camp.
 This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies.
Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.

Name of medication	Date started	Reason for taking it	When is it given	Amount or dose given	How is it given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bed time <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bed time <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bed time <input type="checkbox"/> Other time: _____		

- The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out those the camper should not be given.**
- | | |
|---|---|
| Acelaminophen (Tylenol) | Ibuprofen (Advil, Motrin) |
| Phenylephrine decongestant (Sudafed PEI) | Pseudoephedrine decongestant (Sudafed) |
| Antihistamine/allergy medicine | Guaifenesin cough syrup (Robitussin) |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Dextromethorphan cough syrup (Robitussin OM) |
| Sore throat spray | Generic cough drops |
| Lice shampoo or cream (Nix or Elimite) | Antibiotic cream |
| Calamine lotion | Aloe |
| Laxatives for constipation (Ex-Lax) | Bismuth subsalicylate for diarrhea (Kaapectate, Pepta-Bismal) |

Camper's Name: _____

Diet, Nutrition: Eats a regular diet. Has a medically prescribed meal plan or dietary restrictions: ***(describe below)***

The camper is undergoing treatment at this time for the following conditions: *(describe below)* None.

Other treatments/therapies to be continued at camp: *(describe below)* None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? No Yes

If you answered "Yes" to the question above, what do you recommend? *(describe below—attach additional information if needed)*

I have reviewed, and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except noted above.)

Name of licensed provider (please print): _____ Signature: _____ Title: _____

Office Address: _____
Street City State Zip

Telephone: (_____) _____ Date: _____