



Individualized Order Form

CAMPER: _____ **DATE OF BIRTH:** _____ **WEIGHT:** _____

The following form must be completed and signed by the child’s physician if your child:

- Needs to take any standard Over the Counter Medication “As Needed” provided in the Camp’s Health Center. (Part I)
- Needs to take any routine Prescription Medications, provided by the parent /guardian, while at camp. (Part II)
- Needs to take any Medication “As needed”, provided by the parent /guardian, while at camp. (Part II)

Please Note - This form does not need to be completed or returned if your child will not be taking any medications under any circumstances during their time at camp.

Part I Standard Over the Counter Medications

The following medications are available in the camp health center and will be administered as needed, in accordance with the camp’s written health plan, if approval is indicated by the camper’s healthcare provider, to the child named above.

Drug Name	Route	Dosage	Indications	Physician Order	Comments
APAP Acetaminophen 500mg	PO, Tabs	Per Label	Pain or Fever	Yes No	
Medicaidin-D Chlorpheniramine 2.0mg Acetaminophen 325mg Phenylephrine HCl 5.0mg	PO, Tabs	Per Label	Seasonal Allergies	Yes No	
Sudodrin Pseudoephedrine HCl 30mg	PO, Tabs	Per Label	Nasal Congestion	Yes No	
Alamag Dried Aluminum Hydroxide Gel 300mg Magnesium Hydroxide 150mg	PO, Tabs	Per Label	Upset Stomach	Yes No	
Sepasoothe Cetylpyridinium Chloride 0.5mg Benzocaine 10mg	PO, Lozenge	Per Label	Sore Throat	Yes No	
Calamine Lotion	Topical	Per Label	Allergic Reactions	Yes No	
Bacitracin Zinc	Topical	Per Label	Minor Cuts, Scrapes, Burns	Yes No	
Hydrocortisone 0.5%	Topical	Per Label	Allergic Reactions	Yes No	

Part II Prescription Medications

Please complete with the camper's current regimen for both scheduled and "As Needed" medications. (i.e Epi-Pen.)

Drug Name	Route	Dosage	Indications	Physician Order	Comments

The following information to be completed by the camper's health care provider:

Camper's Health Care Provider Name: _____	Phone #: _____
Address: _____	License #: _____
Physician's Signature: _____	Date: _____

Parent / Guardian's Signature: _____	Date : _____
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Question or Concerns

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