



THIS FORM MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER & BE ACCOMPANIED BY CAMPER'S IMMUNIZATION RECORDS. DUE BY MAY 15, 2019

Camper Name _____ Age/Date of Birth _____

Height _____ Weight _____ Blood Pressure _____ Date of Last Physical Exam _____

The following non-prescription medications are stocked in the Camp Health Center and used on an as-needed basis to manage illness & injury.
MEDICAL PERSONNEL: PLEASE CIRCLE WHICH MEDICATIONS MAY BE ADMINISTERED TO THIS CAMPER AS DIRECTED FOR AGE:

FOR FEVER/PAIN			FOR COLD/ALLERGIES			FOR STOMACH			FOR TOPICAL TREATMENT		
Acetaminophen	Y	N	Tylenol Cold	Y	N	Calcium antacid (Tums)	Y	N	Antibiotic Ointment	Y	N
Ibuprofen	Y	N	Diphenhydramine (Benadryl)	Y	N	Loperamide (Immodium)	Y	N	Caladryl (or Equivalent)	Y	N
			Pseudoephedrine (Sudafed)	Y	N	Docusate Sodium (Stool Softener)	Y	N	Tecnu (Poison Ivy Wash)	Y	N
			Loratadine (Claritin)	Y	N	Pepto Bismol	Y	N	Burn Ointment	Y	N
			Fexofenadine (Allegra)	Y	N				Aloe	Y	N
			Guaifensein (Mucinex)	Y	N				Calamine lotion	Y	N
			Cetirizine (Zyrtec)	Y	N				Hydrocortisone cream	Y	N
			Robitussin DM	Y	N	FOR MOTION SICKNESS			Anti-sting/Itch spray	Y	N
			Cepocol Lozenges/Spray	Y	N	Bonine (Meclizine)	Y	N	White Vinegar Topical	Y	N
			Cough Drops	Y	N	Dramamine	Y	N	Saline Wound Wash	Y	N
									Chloraseptic spray	Y	N

THIS CAMPER WILL TAKE THE FOLLOWING MEDICATION(S) WHILE AT CAMP:

(Please include EPI Pens & Rescue Inhalers, if applicable.)

All medications must come to Camp in their original packaging, prescribed for the camper.

NAME OF MEDICATION	DOSAGE	SCHEDULE	SPECIFIC INSTRUCTIONS

ALLERGIES Please explain specific allergen and reaction: _____

Is this camper being treated for any medical condition(s) at this time? YES NO If YES, please describe condition & treatment:

Do you feel this camper will require limitation or restriction on activities while at camp? YES NO If YES, please describe:

I have reviewed this Camper Health Form and verify the information contained herein. It is my opinion that this camper is physically and emotionally fit to participate in an active camp program.

PHYSICIAN'S
STAMP
HERE

Health Provider Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name (please print) _____

Camper Health Form can be uploaded to your camper's Campinder account, emailed to quinipet@nyac.com, faxed to (631)749-3403 or mailed to: Quinipet, PO Box 549, Shelter Island Heights, NY 11965.
PLEASE BE SURE THIS FORM IS STAMPED AND SIGNED BY BOTH PHYSICIAN AND PARENT