



THIS FORM MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER & BE ACCOMPANIED BY CAMPER'S IMMUNIZATION RECORDS.

PLEASE BE SURE THIS FORM IS STAMPED AND SIGNED BY BOTH PHYSICIAN AND PARENT. DUE BY JUNE 1, 2023

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
			Phenylephrine (Sudafed PE)	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 Lozenge/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
									Swim ear	Y	N

THIS CAMPER WILL TAKE THE FOLLOWING MEDICATIONS, VITAMINS OR SUPPLEMENTS WHILE AT CAMP:

(Please include EPI Pens & Rescue Inhalers, if applicable as well as topical and OTC meds.)

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

NAME OF MEDICATION	DOSAGE	SCHEDULE	SPECIFIC INSTRUCTIONS

ALLERGIES Explain specific allergen and reaction: _____

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

Does this camper 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
(REQUIRED)

Health Provider Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name (please print) _____

Camper Health Form can be uploaded to your camper's CampMinder account either online or via the CampMinder app, emailed to quinipet@nyac.com, faxed to (631)749-3403 or mailed to: Quinipet, PO Box 549, Shelter Island Heights, NY 11965.
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