COOPERSTOWN DREAMS PARK
Camper Examination and Medications

Exam **MUST BE COMPLETED** *within 12 months from the start of camp*

Exam Date:

Camper Last Name: | Camper First Name:

Team Name:: | Date Attending:(from/to) /

This form is to be completed by a Physician, Physician Assistant, or Nurse Practitioner

Health Care Provider:

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted below.

Health Care Provider Name: | Phone:

Address: | License #:

Provider Signature and Practice Stamp:

New York State Department of Health requires that camps have an individualized set of standing orders for each camper attending. This list is for standard "Over the Counter"medications that campers may require while at camp. These medications are available at the camp infirmary.The medications will only be administered at the discretion of a Registered Professional Nurse.

Medications Listed Here:

Dosing will be per label instructions by Age/Weight as needed

A licensed health care provider needs to check the YES box if they wish the child to be eligible to receive the medication indicated.

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Acetaminophen (Tylenol)	☐	☐	Antibiotic Cream	☐	☐	Mylanta	☐	☐	Hydrocortisone 1% Cream
☐	☐	Ibuprofen (Advil)	☐	☐	Calamine Lotion	☐	☐	Zyrtec			
☐	☐	Diphenhydramine (Benadryl)	☐	☐	Antacids (Tums)	☐	☐	Claritin			

All medications sent to camp must be in their original containers, including inhalers, which must come in their prescription labeled box
** No pill boxes, or unlabeled containers will be accepted **

Below, please list any Prescribed, or "Over-the-Counter" medications (not listed above), that the child will provide and take WHILE AT CAMP

Drug Name	Dosage	Route	Schedule / Indication	Comments

The camper is under the care of a physician for the following conditions:

Physician ordered treatments to be continued at camp: