

Medical / Immunization Form

Camper's Name _____

Weight _____

Home Address _____ City _____ State _____ Zip _____ Height _____

Individualized Orders

Standard Over-the-Counter/PRN Medications (available in the infirmary/First Aid Kit) To be administered at the discretion of an RN unless otherwise indicated by you

DRUG (or generic equivalent)	ROUTE	DOSAGE	SCHEDULE	CONTRA-INDICATED Check only if Med. is NOT to be given	COMMENTS
Tylenol	PO	Per label instructions by age/weight	q 6hr prn for discomfort or elevated temp		
Ibuprofen	PO	Per label instructions by age/weight	q 4hr prn for discomfort or elevated temp		
Robitussin	PO	Per label instructions by age/weight	q 4hr prn for cough		
PeptoBismol	PO	Per label instructions by age/weight	q 30 min to 1 hr prn for diarrhea (not >8 doses /24hr)		
Mylanta	PO	Per label instructions by age/weight	TID-QID prn for gastric upset		
Dramamine	PO	Per label instructions by age/weight	½ hr before embarkation, then q 6-8hr prn for motion sickness		
Dimetapp	PO	Per label instructions by age/weight	q 6-8hr for nasal congestion/ drainage		
Benadryl	PO	Per label instructions by age/weight	q 6hr prn for allergic reaction		
Sudafed	PO	Per label instructions by age/weight	g 6-8hr for nasal congestion/ drainage		
Tums	PO	Per label instructions by age/weight	q 30 min prn for gastric upset/ heartburn		
NaphconA	Eye gtts	Per label instructions by age/weight	1-2gtts affected eye for itching/ burning		
Milk of Magnesia	PO	Per label instructions by age/weight	BID-TID prn for gastric upset/ constipation		
Ear Drops	TOP	Per label instructions by age/weight	As indicated		
Cortisone Ointment	TOP	Per label instructions by age/weight	As indicated		
Antifungal Ointment Spray	TOP	Per label instructions by age/weight	As indicated		

SPECIAL RESTRICTIONS:

Diet _____
 Swimming _____
 Strenuous Activity _____
 Other _____

To the best of my knowledge the information stated above is true and accurate and it is my opinion that the camper listed above is physically able to engage in all camp activities, except as noted above.

Physician's Signature _____ Date _____

Physician's Name _____ Phone _____

Immunization History:

Please record month and year of basic immunizations and most recent booster. We do not have it on file from previous years.

Immunization	Date Basic Series Completed	Most Recent Booster
DPT or DT		
TETANUS		
ORAL POLIO		
MMR		
PPD/MANTOUX		
HEPATITIS A		
HEPATITIS B		
VARICELLA		

Allergies	✓	Comments
PENICILLIN		
SULFA		
CEPHALOSPORINS		
Other Medication		
Food Allergies List foods child is allergic to		
Bees/Insect Bites		

Has child ever had an anaphylactic reaction? ☐ Yes
 If yes, are you must send an EpiPen to avoid charges.
 (Check expiration date)

Medical History

Indicate Date of Illness

Chicken Pox _____
 Measles _____
 German Measles _____
 Mumps _____
 Hepatitis _____
 Pneumonia _____

Indicate if being treated for the following:

Diabetes _____ Seizures _____
 Seasonal Allergy _____ Rheumatic Fever _____
 Frequent Ear Infection _____ Frequent Strep Throat _____
 Asthma _____ (If child is being treated for asthma please send along the tubing for the nebulizer as well as all inhalers being used.) Make sure nurse is notified before camp begins.

☐ Positive PPD Date _____ CXRay Date _____

List Dates & Desc. of Operations, Serious Injuries, Etc.

Chronic or Recurrent Illness & Suggested Treatment

Due to recent outbreaks of serious illnesses, Baiseinu can only accept campers & staff members who are fully up-to-date on their vaccinations.