Camp **Hickory Hill**

2970 Kohler Rd.
Varysburg, NY 14167
Ph: (585) 535-7832
Fax: (585) 687-4624

Health Care Provider Form

Dear Health Care Provider,

Your patient:_____________________________DOB:______________is applying to attend a week of summer camp. There will be a Camp Health Director at camp during the week to provide for any health care needs of all campers. In addition to the use of basic medical supplies to provide for general health care, the Camp Health Director is able to consult with an area M.D., P.A. or C.N.P. should the need arise. Your office and the camper's parents would also be contacted should the situation warrant. There is a local hospital approximately 15 miles away where emergency services are available at all times. Please review the following general prn orders and make changes by crossing out standing orders if necessary and writing new orders into the third column under "Doctor's Orders", including any additional OTC or prescription medications. Your signature at the bottom will authorize the Camp Health Director to administer treatment should your patient require general health care during his/her week at camp. (The Camp Health Director meets all certification standards according to the New York State Sanitary Code for Overnight Camps – He or she is typically an RN, but may be an EMT, LPN, MD, PA or CNP.)

Orders for Camp Nursing Care

Camper presents with:	Standing Orders	Doctor's Orders in place of Standing Orders
Seasonal Allergy Symptoms	Benadryl, Loratadine, Cetirizine, or Fexofenadine per dosing instruction.	
Mild Pain	Tylenol or Ibuprofen per dosing instruction.	
Any Anaphylactic Reaction (bee sting, allergy, etc)	Give epinephrine (bee sting kit) and call 911 immediately.	
Stomach upset	Assess for dehydration, give clear liquids. Tums may be given for acid indigestion.	
Fungal-type Skin infections	Apply Clotrimazole cream per dosing instruction.	
Persistent Cough	Mucinex per dosing instruction	
Head Lice	Camper must be sent home	

List all Allergies:

Food: ____

Medications: ____

Insect Stings: ____

Other: ____

List any food or activity restrictions:

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CAMPER'S NAME: ____

Please list ALL medications (including over the counter or nonprescription drugs) taken routinely.

Medication	Dosage	Specific times taken each day	Purpose

Attach additional pages for more medications.

ADDITIONAL PRN MEDICATIONS THAT MAY BE GIVEN: ______________________________

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MEDICATION RESTRICTIONS: ______________________________________

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☐ Please check if the camper must keep their inhaler with them at all times.

Date of last physical exam: ______________

Additional information for the health care staff at Camp Hickory Hill pertinent to this registrant:

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Please attach a copy of immunizations. If no immunizations have been given, we must have documentation attached.

In my opinion, the above registrant is able to participate in an active camp program.

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***Signature of Licensed Medical Personnel** (MD, PA, or CNP ONLY)

**This signature is required for any camper or for any staff member under the age of 19. By signing this form, the MD, PA or CNP is indicating they have read both pages of this health form. An electronic signature is acceptable.*

Printed Name of Physician: ______________________ Date: __________

Physician's Professional License Number: ______________________

Address: ____

City: ____________________ State: _____ Zip: ______ Phone: __________