

Standing Orders

Summer of 2011



P.O. Box 1143
 Ridgewood, NJ 07451
 201.251.0414
 Fax 201.652.7002

The camper's physician must complete both sides of this form. Please return to the camp office by June 1.

Parents, please read: Your child's physician must complete both sides of this form by checking "yes" or "no" on each line and signing at the bottom. By New York state law, we cannot accept a camper at our camps unless both this form and the Physician's Report are properly completed and signed by your camper's physician. A doctor's order of "no" with no alternative listed alongside it means that we cannot administer that medication to your child, no matter how badly it is needed, so please ask your doctor to take the time to complete this form completely. If necessary, you can complete the form and ask your doctor to verify and sign off on it, but we must have this permission from your child's doctor in order to care for your camper.

Child's name Date of Birth.....

Standing Orders for Administration of Over-The-Counter Medication to Child

Standard Over-the-Counter/PRN Medications

The following medications can be administered by camp medical personnel if approval is indicated by the camper's healthcare provider. Unless otherwise specified on this form, the route of administration, dosage, and schedule will be determined based on the manufacturer's instructions as appropriate for camper's age, weight, etc. Generic equivalents of name brands may also be administered; please indicate if a child has an allergy to a specific generic or name-brand drug.

Drug Name	Doctor's Order	Special Instructions for Administration or Alternate Medication
Aleve	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ibuprofen	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Midol	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tylenol	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dimetapp	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Robitussin	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sudafed	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Triaminic	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please complete both pages of this form.

Office Use Only. Please do not place any marks inside this box.

Standard Over-the-Counter/PRN Medications (continued)

Drug Name	Doctor's Order	Special Instructions for Administration or Alternate Medication
Cepacol Lozenges	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chloraseptic Spray	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mylanta / Tums	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pepto Bismol / Immodium	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Benadryl	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hydrocortisone Cream/Ointment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Neosporin / Bacitracin	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dramamine	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nix Lice Shampoo	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Anbesol / Oragel	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Saline / Eye Wash	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Visine	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Aloe	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Epsom Salt	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Licensed Physician's Signature.....

Physician's Printed Name.....

Physician's Address
Street
City, State, Zip
Phone.....
Area Code/Number

Date of Form Completion
*By
*Initial if completed by nurse or physician's assistant.