

Camp Kennybrook 2010
Prescription Medications Form

Individualized Medication orders for :

CAMPERS NAME: _____ **AGE:** _____ **SEX:** _____

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Name of medication: _____

Regimen: Daily: _____ PRN: _____

Date to be started: _____ Date to be discontinued : _____

How many times a day : _____ Times of the day: _____

Please Check : Pill: _____ Liquid: _____

REASON FOR MEDICATION: _____

Any Reactions:

Parent will refill: _____ Camp will refill: _____

Is generic form acceptable? (please circle one) Yes No

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Additional orders (as deemed necessary by health care provider to be implemented by a R.N. ; i.e. peak flows, blood draws, lab work, wound dressing etc.)

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

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ALLERGY SHOTS

Allergy Shots Given : Weekly _____ Every other Week _____ Monthly _____ Other _____

Special instructions: _____

Reactions Noted: _____

Allergist's Name _____ Phone: _____

Signature _____ License # _____

CAMP KENNYBROOK INDIVIDUALIZED ORDERS FOR :

Name: _____ Date of Birth _____

Standard Over the Counter/ PRN medications. The following medications are available to the Camp Nurses and Doctor to be administered per the family physician's instructions.

Medication	Dosage Schedule	Agree with Order	Comments
Acetaminophen Liquid or Tablet	Per label instructions by age/weight	Yes / No	
Ibuprofen Liquid or Tablet	Per label instructions by age/weight	Yes / No	
Cough Suppressants Robitussin	Per label instructions by age/weight	Yes / No	
Pepto Bismal	Per label instructions by age/weight	Yes / No	
Antacids	Per label instructions by age/weight	Yes / No	
Kaopectate	Per label instructions by age/weight	Yes / No	
Diphenhydramine	Per label instructions by age/weight	Yes / No	
Pseudoephedrine	Per label instructions by age/weight	Yes / No	
Chlor-trimeton	Per label instructions by age/weight	Yes / No	
Benedryl-oral for allergic reactions	Per label instructions by age/weight	Yes / No	
Benedryl- IM for allergic reactions	Per label instructions by age/weight	Yes / No	
Topical Antibiotics- Bacitracin, Neosporin	Per label instructions	Yes / No	
Silvadene Cream	Per label instructions	Yes / No	
Topical Antipuities Calamine Lotion	Per label instructions	Yes / No	
Dramamine for motion sickness	Per label instructions by age/weight	Yes / No	

Physician Name: _____ Signature: _____

License# _____ Date: _____ Phone Number: _____