Cary Institute of Ecosystem Studies

MANDATORY PHYSICIAN'S ORDERS for SUMMER CAMP

P.O. Box AB, (2801 Sharon Turnpike) Millbrook, NY 12545
845-677-7600 x 303

This page must be filled out and signed by your child's Physician

Camper's Name: ____ **DOB**: _________________

Camper's Address: ____

Session: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐Art+Sci 1 ☐Art+Sci 2

Standard Over the Counter/PRN Medications

(The following medications are available and will be administered at the discretion of the Health Director or Designee, if approval is indicated by the camper's Healthcare Provider.)

Drug Name	Route	Dosage	Indications	Physician's Order	Comments
Antibiotic Ointment	Topical	Per label instructions	Superficial cuts/abrasions	Yes No	
Hydrocortisone Cream	Topical	Per label instructions	Allergic reactions (contact dermatitis, insect bites)	Yes No	
First Aid & Burn Cream	Topical	Per label instructions	Pain/itching from minor cuts, burns, scrapes	Yes No	
Saline Solution/ Eye Wash	Topical	Per label instructions	Dust/sand/debris in eye	Yes No	
Sting Stop	Topical	Per label instructions	Insect bite or contact with stinging nettle	Yes No	
Alcohol Wipes	Topical	Per label instructions	Superficial cuts/abrasions	Yes No	

Prescription Medications: This includes Epi-Pens, Ritalin, etc. Please complete with the patient's current regimen for both scheduled and PRN medications.

Drug Name	Route	Dosage and Schedule	Indications	Health Care Provider Order	Comments

Campers taking any prescription medications while at camp **MUST be able to self-administer the medication** under the supervision of the Camp Health Director/Designee. Camp Health Directors are only permitted to dispense medications that are listed on this form by the child's doctor.

Physician's Name: ________________________ Phone #: _________________ License #: ________________

Address: ___________________________________ Signature: _________________________ Date: _________

Please remember to complete both sides of this form!

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Immunization Record for Ecology Camp

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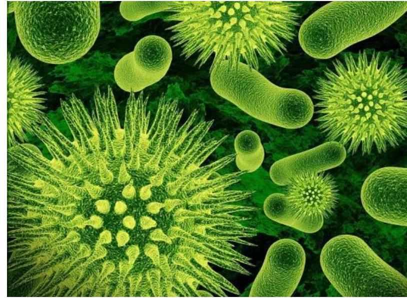

This page (or a similar form showing proof of immunization) must be signed by a Physician

Camper's Name: ____ **DOB:** ________________

Camper's Address: ____

Session: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐Art+Science 1 ☐Art+Science 2

Dear Physician,

Please attach an Immunization Record for the child named above and sign below.

I certify that the attached list of immunizations submitted reflect the required/recommended immunizations for the following diseases:

- Diphtheria
- Haemophilus Influenza B
- Hepatitis B
- Measles
- Mumps
- Pertussis
- Poliomyelitis
- Rubella
- Tetanus
- Varicella – Chicken Pox

Physician's signature ____ Date ________________

Please remember to complete both sides of this form!