CAMP LI-LO-LI MEDICAL FORM
HEALTH CARE PROVIDER CONSENT FOR MEDICATION ADMINISTRATION

Camper Name: _____ Birthdate _____ Weight: _____

HEALTH HISTORY:
(Check if any apply & please explain)
___ Asthma
___ Bed-wetting
___ Bleeding/Clotting disorder
___ Diabetes
___ Frequent ear infections
___ Heart defect/disorder
___ Hypertension
___ Seizures &/or Epilepsy

Emotional/Behavioral disorders or other medical issues (please specify details):
_____
_____
_____
_____

HOSPITALIZATION, MAJOR INJURY, ILLNESS OR SURGERY WITHIN THE PAST YEAR_____
_____
_____

ALLERGIES: (explain reaction as well)
___ Carries Epipen
___ Bees or Insect Bites/Stings
___ Medication : _____
___ Foods (Specify food & reaction): _____
_____
___Other(Specify): _____
_____

DIETARY RESTRICTIONS: _____
_____
_____

Under New York State Law, campers cannot be given ANY medications without the signature of a Health Care Provider (HCP)-- doctor, nurse practitioner or physician's assistant.
If you would like your child to receive **ANY prescription medications** (including inhalers or epi-pens), any **vitamins or herbal supplements,** or any of the **over the counter (OTC) medications listed below** while at camp you must provide camp with **this signed form OR a written order from your Health Care Provider** (MD, NP, PA) **for each medication,** listing specific instructions for administering the medication at camp.
All medications must be brought to camp in the original containers.
For more information, please see our website.

Name of medication:_____ Diagnosis _____
Dosage & Frequency _____ Date order is effective _____
Name of medication:_____ Diagnosis _____
Dosage & Frequency _____ Date order is effective _____
Name of medication:_____ Diagnosis _____
Dosage & Frequency _____ Date order is effective _____
Name of medication:_____ Diagnosis _____
Dosage & Frequency _____ Date order is effective _____

Camper may self-carry medication (Albuterol or Epinephrine) Yes ___ No ___

OTC Medications	HCP Approval	
Acetaminophen (i.e. Tylenol)	O Yes	O No
Ibuprofen (i.e. Advil/Motrin)	O Yes	O No
Antihistamine (i.e. Benadryl)	O Yes	O No
Cough Syrup (i.e. Delsym)	O Yes	O No
Cough drops	O Yes	O No
Decongestant	O Yes	O No
Sunscreen	O Yes	O No
Antacid tablets (i.e. Tums)	O Yes	O No
Antiseptic throat spray	O Yes	O No
Calamine/Caladryl lotion	O Yes	O No
Triple Antibiotic ointment	O Yes	O No
Hydrocortisone cream	O Yes	O No
Allergy tablets (i.e. Claritin)	O Yes	O No

Health Care Provider's Name:

_____
Address: _____

Phone: _____

License #: _____ Date: _____

HCP Signature:

_____

*If you register online, you will still need to send this medical form to the registrar with appropriate signature (e-mail, FAX or mail)

FAX 716-313-1760 Email: registrar@liloli.org

Camper Name: _____