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

**Camper Name** _____ **Birthdate** ____/____/____ **Weight** _____

**HEALTH HISTORY:** (Check all that apply)
[ ] Asthma
[ ] Diabetes
[ ] Heart defect/disorder
[ ] Seizures &/or Epilepsy
[ ] Psychiatric, Emotional or Behavioral Disorder
[ ] Other _____
_____

**MEDICAL ISSUES** (Please provide details)
Include Psychiatric/Emotional/Behavioral disorders
_____
_____

**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): _____
_____

**DATE OF LAST PHYSICAL EXAM** _____

ALL prescription medications (including inhalers or epipens), vitamins, herbal supplements, and over the counter (OTC) medications require this form **signed by your Health Care Provider** (HCP) OR a written order signed by your HCP.

For all the medications listed, please include specific instructions for administering. All **medications must be brought to camp in the original containers**.

**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.**

Please provide **updated immunization records** with this form and **feel free to attach additional medical information** as needed.

**DIETARY RESTRICTIONS:** _____
_____
_____

Camper may **self-carry medication** (Albuterol or Epinephrine)**Yes [ ] No [ ]**

| Medication: Prescribed or over the counter | Diagnosis | Dosage & Frequency | Order Effective Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

| 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 |
| 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: _____