



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

Camper Name: _____

Camper Name _____ Birthdate ____/____/____ Weight _____

HEALTH HISTORY: (Check all that apply)

- Asthma
- Diabetes
- Heart defect/disorder
- Seizures &/or Epilepsy
- Psychiatric, Emotional or Behavioral Disorder
- Other _____

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.**

MEDICAL ISSUES (Please provide details)

Include Psychiatric/Emotional/Behavioral disorders

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.

HOSPITALIZATION, MAJOR INJURY, ILLNESS OR SURGERY WITHIN THE PAST YEAR

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

ALLERGIES: (explain reaction as well)

- Carries Epipen
- Bees or Insect Bites/Stings
- Medication _____
- Foods (Specify food & reaction): _____
- Other(Specify): _____

DIETARY RESTRICTIONS: _____

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

DATE OF LAST PHYSICAL EXAM _____

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

OTC MEDICATIONS	HCP Approval	
Acetaminophen (i.e. Tylenol)	<input type="radio"/> Yes	<input type="radio"/> No
Ibuprofen (i.e. Advil/Motrin)	<input type="radio"/> Yes	<input type="radio"/> No
Antihistamine (i.e. Benadryl)	<input type="radio"/> Yes	<input type="radio"/> No
Cough Syrup (i.e. Delsym)	<input type="radio"/> Yes	<input type="radio"/> No
Cough drops	<input type="radio"/> Yes	<input type="radio"/> No
Decongestant	<input type="radio"/> Yes	<input type="radio"/> No
Antacid tablets (i.e. Tums)	<input type="radio"/> Yes	<input type="radio"/> No
Antiseptic throat spray	<input type="radio"/> Yes	<input type="radio"/> No
Calamine/Caladryl lotion	<input type="radio"/> Yes	<input type="radio"/> No
Triple Antibiotic ointment	<input type="radio"/> Yes	<input type="radio"/> No
Hydrocortisone cream	<input type="radio"/> Yes	<input type="radio"/> No
Allergy tablets (i.e. Claritin)	<input type="radio"/> Yes	<input type="radio"/> 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