



Medical Information for All Camp Participants
DIOCESAN SUMMER CAMPS
Department of Youth and Young Adult Ministries
Diocese of the Armenian Church of America (Eastern)

Examination and Immunization Form

The following information must be completed by a medical provider.

Participant Name: _____ was examined on ____/____/____

Height: _____ Weight: _____ BP: _____

1. In my opinion, the above individual ____ IS ____ IS NOT able to participate in an active camp program.

2. Describe all conditions for which the participant may be under the care of a physician. Note any limitations and/or restrictions while at camp. All medications and treatments prescribed should be listed on Form D:

3. Please attach a printed immunization record from your doctor's office:

****If the participant has NOT been fully immunized due to medical or religious exemption, then please attach the proper documentation from your medical provider.****

Standing Orders for the Administration of Medications Form

The following information must be completed by a medical provider.

In order to administer any medication at St. Vartan Camp / Hye Camp, we require a medical provider signature **and** a parent signature. "Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies, as well as prescribed medications. Medications must be in **the original pharmacy prepared containers** and **labeled with the name of the child**, name of the drug, strength, dosage, frequency, authorized prescriber's name and date of the original prescription. Any modifications to the prescription bottle instruction must have a signed doctor's note. Provide enough of each medication to last the entire time the camper will be at camp. All medications, whether prescribed or over-the-counter, will be returned on the final day of camp; medication that is not picked up on the last day of camp will be destroyed.

PARTICIPANT NAME: _____

Prescription Medications and Over-the-Counter Treatments		
<i>Please complete with current regimen for both scheduled and as-needed medications, in addition to any other orders deemed necessary to be implemented by the camp nurse/doctor (i.e., dressing changes, cast care, special dietary instructions).</i>		
Medication	Dose, Route, and Frequency	Indication, other comment(s)

Standard Over-the-Counter Medications, First Aid, and Preventative Treatment		
<i>The following non-prescription medications may be stocked in the camp health center and may be used on an as-needed basis to manage illness and injury at the nurse/doctor's discretion. CROSS OUT any medications the camper should NOT be given.</i>		
Acetaminophen (e.g. Tylenol)	Ibuprofen, (e.g. Advil, Motrin)	Naproxen (e.g. Aleve)
PMS/Menstrual Relief (e.g. Midol, Pamprin)	Body Powder (e.g. Gold Bond)	Dietary Fiber (e.g. Metamucil, Benefiber)
Cough Medication (e.g. Robitussin, Nyquil)	Decongestant (e.g. Dimetapp, Sudafed)	Antihistamine (e.g. Benadryl, Claritin)
Throat Spray (e.g. Chloraseptic)	Cough Drops (e.g. Halls)	Canker Sore Relief (e.g. Orajel)
Antacid (e.g. Tums, Mylanta, Maalox)	Anti-diarrheal (e.g. Imodium, Pepto Bismol)	Laxative (e.g. Milk of Magnesia, Dulcolax)
Antiseptic Cleanser (e.g. Bactine)	Antibiotic Ointment (e.g. Neosporin)	Steroidal Ointment (e.g. Hydrocortisone)
Topical Antihistamine (e.g. Benadryl, Calamine)	Sun care (e.g. Sunscreen, Aloe Vera, Solarcaine)	Bug Repellent (e.g. Off!)
Eye Drops/Lubricant (e.g. Visine)	Swimmer's Ear Drops (e.g. Auro-Dri, Swim Ear)	Athletes Foot Care (e.g. Tinactin)

MEDICAL PROVIDER SECTION: <i>I have completed and verified the medical information listed above.</i>	
Signature/Stamp of Medical Provider: _____	
Printed: _____	Date: _____
Address: _____	
Phone: _____	Fax: _____

PARENT/GUARDIAN/STAFF SECTION: <i>I have read the above statements and agree to their terms.</i>	
Signature: _____	
Date: _____	