Complete ALL areas. ***Incomplete forms will be returned!***

Camper Name:	Sex: ☐M ☐F	Age:	DOB:
Camper Address:	DDS#:		SSN#:
Insurance Company:		Insurance Number:	

The remaining sections of pages A-D MUST be completed and signed by a PHYSICIAN!

Height		Weight		BP	

Diagnosis and Pertinent Information:

Allergies:

Required Adaptive Equipment: *(braces, utensils, etc.)*

Past / Prospective Surgeries:

Mobility: ☐ Independent Ambulation ☐ Assisted Ambulation ☐ Wheelchair

Shunt Present? ☐Yes ☐No Date of last revision: _____ / _____ / _____

Does Camper Require Bedrails? ☐Yes ☐No Does Camper Require Bedrail Pads? ☐Yes ☐No

Campers must supply own bed rail pads.

Restraints: ☐Yes ☐No	Specify Reason and Kind:

Physician Initials:	

Camp Harkness Medical Form (cont.)

Special Diet: ☐ Whole ☐ Chopped ☐ Ground ☐ Puree		Liquid Consistency: ☐ Thin ☐ Nectar ☐ Honey ☐ Pudding
Asthma: ☐ Yes ☐ No	Immunizations Complete: ☐ Yes ☐ No	**Date Last Tetanus:** ____ / ____ / ____
	COVID Vaccination: ☐ Yes ☐ No	**Date:** ____ / ____ / ____
	COVID Vaccination: ☐ Yes ☐ No	**Date:** ____ / ____ / ____
	COVID Booster Vaccination: ☐ Yes ☐ No	**Date:** ____ / ____ / ____
	COVID Booster Vaccination: ☐ Yes ☐ No	**Date:** ____ / ____ / ____
Seizures: ☐ Yes ☐ No Type: _____	Frequency: _____	Date of last seizure: ____ / ____ / ____
Diabetes : ☐ Yes ☐ No Controlled by: ☐ Diet ☐ Oral Medication ☐ Injection		*PLEASE FILL OUT DIABETIC PROTOCOL SECTION*

Diabetic Protocol

Diet Restrictions:	
Can camper have a single serving of special treats once per day during camp programs? (e.g. one s'more, small ice cream cup, small piece of birthday cake)	☐ Yes ☐ No
Please list any specific requirements for monitoring the camper's recreational activities:	
Glucose Testing?	☐ Yes ☐ No
Glucose Monitoring Schedule (please note days and frequency): _____ _____	
Notify Doctor if BS is < _____ or > _____	
(Please include insulin sliding scale or oral medication adjustments on Medication Order Sheet)	
Camper's desired test range:	
Does camper use Glucagon? (Please include order on Medication Order Sheet)	☐ Yes ☐ No

Please indicate current or past difficulties in the following systems/areas, including surgeries:

Auditory	☐ Yes ☐ No	Muscular	☐ Yes ☐ No	*Please comment on any items marked "Y":*
Visual	☐ Yes ☐ No	Balance	☐ Yes ☐ No	
Tactile Sensation	☐ Yes ☐ No	Orthopedic	☐ Yes ☐ No	
Speech	☐ Yes ☐ No	Allergies	☐ Yes ☐ No	
Cardiac	☐ Yes ☐ No	Learning Disability	☐ Yes ☐ No	
Circulatory	☐ Yes ☐ No	Cognitive	☐ Yes ☐ No	
Integumentary/Skin	☐ Yes ☐ No	Emotional/Psychological	☐ Yes ☐ No	
Immunity	☐ Yes ☐ No	Pain	☐ Yes ☐ No	
Pulmonary	☐ Yes ☐ No	Other:	☐ Yes ☐ No	
Neurologic	☐ Yes ☐ No			

FOR PERSONS WITH DOWN SYNDROME: Neurological symptoms of Atlantoaxial Instability ☐ Present ☐ Not Present

Camp Activities:

May Participate in all Camp Activities: ☐ Yes ☐ No List Exceptions:

Physician Initials:

Medication Order Sheet

Must be completed and initialed by physician

Camper Name: _____

***Discontinue** all nonessential vitamins, creams, and ointments for the duration of the camper's stay.*

Please complete all sections completely, including **DOSE, ROUTE** and **INTERVAL**.

#	Drug Name	Dose	Route	Interval			
				AM	Noon	Din	HS
1							
	Special Instructions:						
2							
	Special Instructions:						
3							
	Special Instructions:						
4							
	Special Instructions:						
5							
	Special Instructions:						
6							
	Special Instructions:						
7							
	Special Instructions:						
8							
	Special Instructions:						
9							
	Special Instructions:						
10							
	Special Instructions:						
			Physician Initials:				

Physician's Standing Order Sheet

The following Standing Orders are established to provide Medical Personnel directions to treat minor health conditions. When standing orders are used, the staff will document appropriately. If symptoms persist, camp nursing staff will notify camp doctors or outside physician for further instructions.

Please modify doses for campers if necessary.

Camper Name: _____ **Date :** _____ / _____ / _____

Abrasion or Laceration
1. Clean with soap and water or wound wash saline and remove debris
2. Apply bacitracin topically
3. Cover with dry sterile dressing
4. Repeat until healed

Athlete's Foot
1. Desenex anti-fungal powder BID topically
2. Review in two (2) weeks for effectiveness

Bee Sting or Insect Bites
1. Apply cool compress for pain and swelling
2. Apply Caladryl or Calamine lotion to relieve itching
3. Benadryl 25mg PO for excessive itching
4. Administer EpiPen for anaphylaxis and call 911

Bites, Human
1. Cleanse with soap and water
2. Check tetanus status
3. Call MD or seek medical treatment

Bites, Tick
1. Remove Tick
2. Cleanse area
3. Apply bacitracin
4. Monitor for increased redness of area or "Bulls Eye Rash"
5. Monitor for malaise, low grade temp or muscle/joint pain

Blistex / ChapStick
1. Apply Q 4 Hrs PRN for dry, chapped or sunburned lips

Burns
1. Flush with cold water
2. Observe for blisters / infections
3. Report to physician accordingly

C/O Headache, General Discomfort
1. Tylenol 500mg or Motrin 400mg PO Q 4 Hrs PRN X 24 Hrs
2. Observe for additional symptoms
3. Report to MD if condition persists

C/O Indigestion
1. 10 ml of Mylanta PO PRN Q 4 Hrs
2. Limit to 6 doses in 24 Hrs
3. Sip Ginger Ale
4. If pain persists, seek medical treatment

Constipation
1. 6 oz. prune juice on 2nd day if no BM
2. Dulcolax supp. PRN on 3rd day if no BM
3. Fleet on 4th day if no BM
4. If no result, seek medical attention

Contusions
1. Apply ice pack X 15 minutes
2. Monitor for bruising

Cough / Cold
1. Robitussin 10 cc PO Q 4 hours. Do not exceed more than 6 doses in 24 hrs.
2. Push clear fluids
3. Observe for other symptoms (TPR)
4. If cough persists, temperature spikes or respiratory distress occurs, call MD or seek medical treatment

Diarrhea (After 2nd incident)
1. Clear liquids X 24 to 48 Hours
2. Hold stool softeners X 24 Hours
3. No fruit juices
4. Monitor intake and output
5. Imodium AD-2mg PO (per package instructions)
6. Call MD if diarrhea persists (per package instructions)

Elevated Temperature Above 101 degrees
1. Tylenol 500mg PO Q 4 Hrs PRN X 24 Hrs
2. Force fluids
3. TPR Q 4 Hrs X 48 Hrs
4. Call MD if temperature persists

Groin Rash
1. Zinc oxide to be applied PRN for groin rash topically
2. Must wash and dry well between application

Irritated Eyes
1. Artificial Tears 2 drops each eye, PRN Q 4 Hrs

Menstrual Cramps *(choose one of the listed medications below)*
1. Advil 2 Tabs Q 4 Hrs PRN
2. Midol 2 Tabs Q 4 Hrs PRN

List RX Alternative:

Runny Nose
1. Dimetapp Elixir * 4 tsp Limited to 4doses in 24 hrs.

List and provide RX Alternative:

Rashes (Generalized)
1. Apply cortisone cream 1% topically to affected area 3 times daily X 72 Hrs
2. Call MD if rash persists

Sunburn (use sunscreen SPF 15 and above)
1. Mild to Moderate: Cool Compress
2. Apply Aloe to affect areas
3. Blisters: Call MD / Seek medical treatment

Vomiting
1. NPO X 2 Hrs Then:
2. Clear liquids slowly as tolerated (Jell-O, ice pops, 7-Up, Ginger Ale, Kool Aid)
3. No Tea, Coke, or coffee
4. VS/shift X 24
5. Monitor intake and output
6. If condition persists, notify MD

Potassium Iodide (KI) Tablets

1. Use only as directed by State or Local Public Health Authorities in the event of a radiation emergency
2. Give one tab (130mg) of Potassium Iodide to adults and children over one (1) year of age. This tablet should be crushed and added to food for small children

The preceding orders will be in effect from: **June 1, 2024 to December 31, 2024** *(May be substituted for generic brands)*

Physician Name (print) MD DO Other: ____	*Physician Signature*	*Date*
Physician Address		*Telephone*