**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 ☐ Cut-Up ½" pieces ☐ Chopped ¼" pieces ☐ Ground ☐ Puree
Liquid Consistency: ☐ Thin ☐ Nectar ☐ Honey ☐ Pudding

| | |
|---|---|
| Asthma: ☐ Yes ☐ No | **Date Last Tetanus:** _____ / _____ / _____ |

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

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

**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

**Sun Exposure**
1. Apply sunscreen, SPF 50, to areas of exposed skin as often as needed.

**COVID Symptoms**
1. May use At-Home COVID-19 test kit PRN for exposure or signs of COVID-19 per RN directive.

## *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, 2025 to December 31, 2025** *(May be substituted for generic brands)*

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