

INDIVIDUALIZED STANDING ORDERS

Name: _____ Date of Birth: ____ / ____ / ____ Camp Session: _____

A: TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER:

Standard Over-the-Counter/PRN Medications – The following medications are available in the Camp Health Office and will be administered at the discretion of an EMT, if approval is indicated by the camper's health care provider.

Dosage and schedule will be per label by age/weight.

| Drug Name | Route | Doctor's Order Check one | | Comment |
|--|------------------|-----------------------------|--------------------------|------------------|
| | | YES | NO | |
| Tylenol (Acetaminophen) | PO – tablet | <input type="checkbox"/> | <input type="checkbox"/> | Fever > _____ °F |
| Advil/Motrin (Ibuprofen) | PO – tablet | <input type="checkbox"/> | <input type="checkbox"/> | Fever > _____ °F |
| Benadryl (Diphenhydramine Hydrochloride) | PO | <input type="checkbox"/> | <input type="checkbox"/> | |
| Bacitracin or Neosporin Ointment | Topical ointment | <input type="checkbox"/> | <input type="checkbox"/> | |
| Calamine or Campho-phenique | Lotion | <input type="checkbox"/> | <input type="checkbox"/> | |
| Solarcaine or Nupercaine burn spray | Liquid spray | <input type="checkbox"/> | <input type="checkbox"/> | |
| Dimetapp | PO - elixir | <input type="checkbox"/> | <input type="checkbox"/> | |
| Pepto Bismol | PO | <input type="checkbox"/> | <input type="checkbox"/> | |
| Sucrets or Chloraseptic Lozenges | PO – lozenge | <input type="checkbox"/> | <input type="checkbox"/> | |
| Tylenol Cold | PO – tablet | <input type="checkbox"/> | <input type="checkbox"/> | |
| Milk of Magnesia | PO | <input type="checkbox"/> | <input type="checkbox"/> | |
| Robitussin DM Cough Syrup | PO – syrup | <input type="checkbox"/> | <input type="checkbox"/> | |
| Dacriose | Rinse – eye | <input type="checkbox"/> | <input type="checkbox"/> | |
| Tums | Tablets | <input type="checkbox"/> | <input type="checkbox"/> | |
| Murin or Visine eye drops | Eye drop | <input type="checkbox"/> | <input type="checkbox"/> | |
| Rhuli Gel or Hydrocortisone Ointment | Topical ointment | <input type="checkbox"/> | <input type="checkbox"/> | |
| Kaopectate | PO | <input type="checkbox"/> | <input type="checkbox"/> | |

Prescription Medications – Please complete the patient's current regimen for both scheduled and PRN medications.

| Drug | Route | Dosage | Schedule and Indications | Comments |
|------|-------|--------|--------------------------|----------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Health Care Provider's Name: _____ Phone: (____) _____ - _____

Address: _____ License #: _____

Health Care Provider's Signature: _____ Date: ____ / ____ / ____

B: TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that my child _____ receive the medication as prescribed by our licensed health care provider. Prescription medications and any over-the-counter medications not made available by the camp are to be furnished by me in the properly labeled container from the pharmacy. I understand that the camp medical officer will supervise the administration of the medication.

Parent's Signature: _____ Date: ____ / ____ / ____