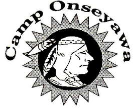


ROTARY CAMP ONSEYAWA
STATEMENT OF ATTENDING PHYSICIAN

(revised 3/2010)

Dear Physician,

The Rotary Clubs of Ontario, Seneca, Yates and Wayne Counties annually provide a cost-free summer camping experience for children with disabilities. Campers attend an overnight session of Rotary Camp Onseyawa in August. The camp is at Babcock-Hovey Boy Scout Camp in Ovid, NY. Camp Onseyawa serves campers between the ages of 8 and 16.

The success of this camp for individuals with disabilities largely depends upon the camper. Those responsible for selection of eligible campers do not as a rule see the campers until after their arrival at camp. It is exceedingly important therefore, that you answer all the following questions completely and candidly. You may be assured that all information will be kept in strict confidence. We will use the information only to help us in selection of campers and to provide adequate care during their time with us. **The selection committee will not accept a camper until all the forms have been received.** Please send completed form by June 1st, 2010 to:

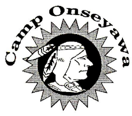
Rotary Camp Onseyawa
Sandy Ottley
PO Box 614
Geneva, NY 14456
(315) 585-6323

Delay in processing the child's application and possible applicant refusal will result if this from is incomplete or ambiguous.

We appreciate your cooperation in helping us select individuals who are able to participate in the activities of our summer overnight camping experience.

Sincerely

Rotary Camp Onseyawa Selection Committee



ROTARY CAMP ONSEYAWA
STATEMENT OF ATTENDING PHYSICIAN
(revised 8/2003)

PLEASE PRINT OR TYPE
Child's Name ____ Birthdate ____ / ____ / ____
Home Address ____ Phone (____) ____________

____

Parents or Legal Guardian ____
****
Primary Handicapping Condition ____
Additional Diagnoses ____

Required Immunizations	Dates of 1st series			Dates of boosters	
	1st	2nd	3rd	1st	2nd
Td					
DPT					
Polio (oral / inj.?)					XXXXX
MMR			XXXXX	XXXXX	XXXXX
Hepatitis B					

Physical Restrictions _______________________
____
____
____

Special Equipment ____________________
____
____
____

Dietary Restrictions _______________________
____
____
____

Allergies ____________________________
____
____
____

Medical / Surgical History _________________
____
____
____

____
____

Seizure History z Yes z No
Type _______________________________
Description __________________________
____

____
____

Special Exercises / Treatments ____
____
Comments / Concerns ____
____
____
____

____

(Continued on Back of Form)

ROTARY CAMP ONSEYAWA

STATEMENT OF ATTENDING PHYSICIAN

(revised 7/2001)

Medications orders

If a child is to get any medications during Camp (including Over-the-Counter medications), This form must be completed and brought to camp at Check-in.

- Medication(s) must be in original containers with clear, correct labels.
- No changes will be made without a Doctors/Nurse Practitioner's written order

Part I

(To be completed by the doctor or nurse practitioner)

______________________________ should receive the following medications at camp:
(Name of Child)

Medication____
Strength (mg)_______________________________________
Dose ____
Frequency/Time to be given @ camp ________________________

Medication____
Strength (mg)_______________________________________
Dose ____
Frequency/Time to be given @ camp ________________________

Medication____
Strength (mg)_______________________________________
Dose ____
Frequency/Time to be given @ camp _______________________

Medication____
Strength (mg)_______________________________________
Dose ____
Frequency/Time to be given @ camp ________________________

Medication____
Strength (mg)_______________________________________
Dose ____
Frequency/Time to be given @ camp ________________________

Medication____
Strength (mg)_______________________________________
Dose ____
Frequency/Time to be given @ camp ________________________

Doctor's/ Nurse Practitioner's Signature__________________________________ Date: ______________
Doctor's/Nurse Practitioner's Name (*please print*): __________________________ Phone:________________

Part II

(To be completed by parent/guardian)

I request that the medication(s) listed above be administered by camp nursing staff.

____ ________________ __________________
Signature of parent/guardian Date Relationship to child

The following is a list of over-the-counter medication available for dispensing at camp. Please indicate with a check mark if this patient may receive these medications.

ü Acetaminophen 15mg/kg Q4hr PRN temp > 101 F, minor pain or discomfort.

ü Ibuprofen 200mg-400mg Q4-6hr PRN minor pain or discomfort.

ü Robitussin DM 1-2 Tsp. PO Q6-8hr PRN coughing.

ü Benadryl Elixir / capsule 15mg-25mg PO Q6-8hr (5mg/kg/24hr) PRN not to exceed 300mg/24hr, minor allergic reaction, severe puritis.

ü Milk of Magnesia 15cc-30cc PO QD PRN constipation.

ü Chloraseptic Spray PO Q2-4 hr PRN minor throat discomfort.

ü Triple Antibiotic Ointment apply topically to affected area PRN minor cuts / abrasions.

ü Caladryl lotion apply topically to affected area PRN minor itching.

ü Kaopectate 30-60 ml PO PRN after each loose BM, not to exceed 6 doses/day or a period > 48hrs.

ü "After Bite" (Ammonium Hydroxide) apply topically to insect bites PRN itching.

****

NOTE: If there are any changes in medications or other medical information after this form is submitted, please notify the camp in writing.

****

I recommend this child for the camp program, believing that he / she will benefit from the camp experience and will not endanger, or be endangered by, the group and its activities.

Physician's signature ____ Date ____ / ____ / ____

PLEASE PRINT

Name ____

Address ____

____

Phone _________________________