

STEVE'S CAMP

Medical Authorization form

To the camper's healthcare provider: Please complete this medical authorization form in its entirety. If it is helpful, complete it in the company of the patient and the caregiver during the physical examination, as some questions pertain to the child's personal or religious dietary restrictions.

Patient first name	Patient last name	Date of birth	Date of physical examination
_____	_____	_____ <i>Month/day/year</i>	_____ <i>Month/day/year</i>
Patient's height	Patient's weight	Patient's blood pressure	
_____	_____	_____	

Immunization

Please provide a copy of the patient's immunization history.

Medication Usage

Please include the patient's current regimen for both scheduled and prescription medications. This includes vitamins, inhalers, epipens, and ear and eye drops. Medications sent to camp with the camper must be in the original labeled bottle with directions for administration.

Prescribed Medications

Please list all of the patient's medications in this format: drug name, route of administration, dosage, schedule and indications, and any comments that would be helpful to camp staff:

Please confirm by checking "yes" or "no" whether the patient can receive any of the following over-the-counter medications:

Acetaminophen	Yes	No	Benadryl	Yes	No
Ibuprofen or other NSAIDs	Yes	No	Pseudoephedrine HCL	Yes	No
Robitussin cough syrup	Yes	No	Bacitracin ointment	Yes	No
Children's Mylanta	Yes	No	Caladryl/Calagel	Yes	No

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Dietary Limitations and Physical Readiness for Camp

List the patient's medication/treatment to be continued at camp:

List all known allergies (food, environmental, et cetera):

List the patient's special dietary routines or dietary restrictions (due to health reasons, religious reasons, or personal preferences):

List the patient's physical limitations or restrictions for participating in camp activities:

In my opinion, the camper may participate in an active summer program and all of its activities:

Yes No

Healthcare Provider Information

Healthcare provider's name

Healthcare provider's license number

Healthcare provider's address

Healthcare provider's phone number

I hereby certify that everything stated is true and this statement can act as a signature.