

**Pine Bush Bible Camp- ADULT STAFF Medical Report (all staff under 18
must complete camper/minor staff medical form and medication orders)**

Name _____ Date of Birth _____ Phone _____
Address _____ City _____ State _____ Zip _____

IN CASE OF EMERGENCY NOTIFY: _____

PHONE _____ ADDRESS _____

Have you had any of the following:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Severe Earache | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Convulsion | <input type="checkbox"/> Hernia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Disease/Eczema |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Chicken Pox | | | |

Do you now have any of the disease above (or any other medical condition)? YES NO If yes, please explain

What operations have you had and when? _____

Date and reason for last Doctor visit: _____

Do you have any of the following allergies:

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Asthma (must bring medication) | <input type="checkbox"/> Serious Ivy, oak or Sumac poisoning |
| <input type="checkbox"/> Bee Sting | <input type="checkbox"/> Medication _____ | <input type="checkbox"/> Other _____ |

List any Dietary or Activity restrictions: _____

List any other information we should be aware of _____

Immunization Record:

Last Tetanus Shot _____

Mantoux _____ Results negative positive If positive, please indicate date of chest x-ray and results
_____ and any treatment received _____

List any prescription and daily medications and physicians directions:

Note: Our medical insurance has limitations based upon your family's medical insurance coverage. Any medical cost incurred while at PBBC that is in excess of \$100 must be submitted to your medical insurance carrier for payment. If there is any portion of the cost unpaid by your medical insurance carrier, those costs will then be submitted to the camp's medical insurance carrier.

Personal Insurance Coverage and policy number: _____

PINE BUSH BIBLE CAMP Medication form (to be completed by MD)

Individualized orders for: Name _____ **DOB:** _____ **Weight:** _____

Standard Over the Counter/PRN Medications (The following medications are available in the health center and will be administered at the discretion of an RN, if approval is indicated by the camper's healthcare provider):

Medications	Route	Dosage	Schedule and Indications	Camper Health Care Provider order	Comments
Acetaminophen (Tylenol)	PO (chewable tabs, elixir or tabs)	Per label instructions by age/weight	Q 4 hr for pain or fever	Yes No	
Ibuprofen (Advil, Motrin)	PO (chewable tabs, suspension or tabs)	Per label instructions by age/weight	Q 6 hr for pain or Fever	Yes No	
Robitussin or Robitussin DM (guaifensin/Dextromethorphan Hbr)	PO (syrup)	Per label instructions by age/weight	Q 4 hr PRN for cough	Yes No	
Bismuth (Pepto-Bismol)	PO (liquid or chewable tabs)	Per label instructions by age/weight	Q 30 min to 1 hr PRN for diarrhea, nausea (no > 8 doses/24 hr)	Yes No	
Children's Mylanta	PO (liquid or chewable tabs)	Per label instructions by age/weight	BID-TID PRN stomach upset	Yes No	
Diphenhydramine Hydrochloride (Benadryl)	PO (elixir, chewable tabs or pills)	Per label instructions by age/weight	Q 6 hr PRN for allergic reaction (hives, insect bite)	Yes No	
Pseudoephedrine HCL (Sudafed)	PO (elixir or pills)	Per label instructions by age/weight	Q 4 hr PRN for nasal congestion/drainage	Yes No	
Loperamide HCL (Immodium)	PO (liquid or pills or chewable tabs)	Per label instructions by age/weight	Q 6-8 hours for diarrhea	Yes No	
Midol	PO (caplets or gel caps)	Per label	Menstrual cramps or bloating	Yes No	
Lotrimin/Tolfanate	Cream/spray	Per label	Rash/athletes foot	Yes No	
Hydrocortisone	Cream	Per label	Rash, bug bites	Yes No	
Antibiotic Ointment	Cream	Per label	Cuts	Yes No	
Diphenhydramine Hcl (Benadryl)	Cream/gel	Per label	Bug bites	Yes No	
Calamine	Lotion/spray	Per label	Bug bites/rashes	Yes No	
Anbesol	Liquid	Per label	Toothache	Yes No	
Lice Shampoo	Liquid	Per label	Lice	Yes No	
Iodine	Liquid	Per label	Cleanse abrasions	Yes No	
Sting Kill Swabs	Swab/pad	Per label	Bee/Wasp stings	Yes No	
Visine	Drops	Per label	Red itchy eyes	Yes No	
Cough drops	Lozenges	Per label	Sore throat/cough	Yes No	
Phenol (Sore throat spray, Chloraseptic)	Spray	Per label	Sore throat/canker sore	Yes No	

Prescription/ Additional OTC Medications (Please list the patient's current regimen for **BOTH SCHEDULED AND PRN** medications- attach a separate paper if needed)

Additional Orders (as deemed necessary by health care provider to be implemented by an RN; i.e. peak flow, dressing changes, cast care, etc.)

Please attach a copy of the camper's immunization record.

Camper's Health Care Provider Name (please print): _____

Phone number: _____

MD Signature: _____ Date: _____