

# Medication Orders – Youth Camp - 2023

Delta Lake Bible Conference Center  
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Camper Name \_\_\_\_\_

Gender: M / F \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Session (circle one) Ignite (grades 3-5) Launch (grades 6-8) Liftoff (grades 9-12)

<p><b>Before Camp:</b></p> <ul style="list-style-type: none"> <li>Written medication orders signed by the MD must be mailed or faxed to camp with registration forms.</li> <li>Copies of current prescriptions will be accepted for the MD signature when attached to this COMPLETED form.</li> </ul>	<p><b>During Camp:</b></p> <ul style="list-style-type: none"> <li>Nursing staff will administer medications to all campers.</li> <li>Medications will be kept in the locked cabinet at the nurses' station.</li> </ul>
<p><b>At Registration:</b></p> <ul style="list-style-type: none"> <li>All medications must be delivered to the camp nurse by a parent. All medication must be in the original container with the pharmacy label securely attached.</li> <li>Unlabeled medication or preparations will not be accepted.</li> <li>Any corrections to the orders (i.e. additional or discontinued medicines) must have written verification from the MD.</li> </ul>	<p><b>At End of Camp:</b></p> <ul style="list-style-type: none"> <li>Campers will be released from the Main Tab.</li> <li>The nursing staff will return all medications to the parent at the Guest Services building.</li> </ul> <p><b>List Camper Allergies:</b>    <input type="checkbox"/> No Known Allergies</p> <ul style="list-style-type: none"> <li>_____</li> <li>_____</li> <li>_____</li> </ul>

There will be limited OTC medications at camp for unexpected health issues. Please indicate if they should be made available to this camper.	Medications	Dosage	Indications	MD approval
	Calamine / Caladryl	as per label	for minor reaction to bug bites	YES / NO
	Antibiotic Ointment	as per label	for minor wounds	YES / NO
	Benadryl	as per label	for allergic reactions	YES / NO
	Acetaminophen	as per label	for relief of pain / fever	YES / NO
	Ibuprofen	as per label	For relief of pain / swelling / fever	YES / NO

Medication	Dosage	Route	Frequency	√ Check times to be given during camp session			
				8a	12n	5p	HS
1.							
2.							
3.							
4.							
5.							
6.							

Physician's Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

PRINT Physician's Name \_\_\_\_\_

Telephone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

**AND**

Parent signed approval: \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_