

Dear Physician:

Please complete and submit the following form for OTC medication administration on behalf of _____.

Who will be attending Pioneer Camp and Retreat Center on _____. Please fax this form no later than seven days prior to the above named campers arrival at (716)549-6018.

Parent/Guardian Signature

Date

Pioneer Camp and Retreat Center, Inc.
9324 Lakeshore Road Angola NY 14006
716-549-1420 Phone 716-549-6018 Fax

PHYSICIAN INDIVIDUALIZED ORDERS for:

Camper Name: _____ DOB: _____ WEIGHT: _____

Standard Over the Counter/PRN Medications (The following medications are available in the infirmary and will be administered at the discretion of a RN, if approval is indicated by the camper's physician.)

Drug Name	Route (please circle formulation(s))	Dosage	Schedule and Indications	Physician Order	Comments
Tylenol	PO (chewable tabs, elixir or tabs)	Per label Instructions by age/weight	Q 4 hr pm for pain or fever > _____ F	Yes No	
Ibuprofen	PO (chewable tabs, elixir or tabs)	Per label instructions by age/weight	Q 6 hr pm for pain or fever > _____ F	Yes No	
Robitussin	PO (Syrup)	Per label instructions by age/weight	Q 4 hr pm for pain or fever > _____ F	Yes No	
Pepto Bismol	PO (liquid, or chewable tabs)	Per label instructions by age/weight	Q 30 min to 1 hr pm for Diarrhea (no. 8 doses / 24 hr.)	Yes No	
Dimetapp	PO (elixir or tabs)	Per label instructions by age/weight	Q 6-8 hr pm for nasal congestion / drainage	Yes No	
Benadryl	PO (elixir, chewable tabs or pills)	Per label instructions by age/weight	Q 6 hr pm for allergic Reaction (hives, insect bite)	Yes No	

Camper's Physician's Name: _____

Address: _____

Phone #: _____ License #: _____

Physician's Signature: _____ Date: _____