INDIVIDUALIZED STANDING ORDERS

Name: _____ Date of Birth: ____/____/____ Camp Session: _____

A: TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER:

Standard Over-the-Counter/PRN Medications – The following medications are available in the Camp Health Office and will be administered at the discretion of an EMT, if approval is indicated by the camper's health care provider.

Dosage and schedule will be per label by age/weight.

Drug Name	Route	Doctor's Order Check one		Comment
		YES	NO	
Tylenol (Acetominophen)	PO – tablet	❑	❑	Fever >_____ºF
Advil/Motrin (Ibuprofen)	PO – tablet	❑	❑	Fever >_____ºF
Benadryl (Diphenhydramine Hydrochloride)	PO	❑	❑	
Bacitracin or Neosporin Ointment	Topical ointment	❑	❑	
Calamine or Campho-phenique	Lotion	❑	❑	
Solarcaine or Nupercaine burn spray	Liquid spray	❑	❑	
Dimetapp	PO - elixir	❑	❑	
Pepto Bismol	PO	❑	❑	
Sucrets or Chloraseptic Lozenges	PO – lozenge	❑	❑	
Tylenol Cold	PO – tablet	❑	❑	
Milk of Magnesia	PO	❑	❑	
Robitussin DM Cough Syrup	PO – syrup	❑	❑	
Dacriose	Rinse – eye	❑	❑	
Tums	Tablets	❑	❑	
Murin or Visine eye drops	Eye drop	❑	❑	
Rhuli Gel or Hydrocortisone Ointment	Topical ointment	❑	❑	
Kaopectate	PO	❑	❑	

Prescription Medications – Please complete the patient's current regimen for both scheduled and PRN medications.

Drug	Route	Dosage	Schedule and Indications	Comments

Health Care Provider's Name: _____ Phone: (_____)_____-_____

Address: _____ License #: _____

Health Care Provider's Signature: _____ Date: ____/____/____

B: TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that my child _____ receive the medication as prescribed by our licensed health care provider. Prescription medications and any over-the-counter medications not made available by the camp are to be furnished by me in the properly labeled container from the pharmacy. I understand that the camp medical officer will supervise the administration of the medication.

Parent's Signature: _____ Date: _____/_____/_____

COPY AS NEEDED