Adirondack Baptist Camp 2024 **Registration due August 7th**

Camper's Name: ______________________________ D O B :   /   /

Parents or Guardians, please fill out the appropriate information for your child.

Attach a copy of your shot records. (Check your local school or doctor's portal.)

Approval /Disapproval of Administration of Medication

The following may be administered to your child, if needed, while at camp. Indicate approval/disapproval if administered by camp medical personnel as needed. **Your physician's signature and approval is required.**

LHCP Order Yes or No	Medication Name	Comments	
	Acetaminophen	325mg mg PO q4 hrs prn MDD 3000 mg	Pain, discomfort, fever
	Ibuprofen	200mg mg PO q4 hrs prn MDD 2400 mg	Pain, discomfort, fever
	Diphenhydramine HCL	25mg mg PO q4 hrs prn MDD 150 mg	Itching, congestion
	Cough drops/Tums	PO q2 hrs prn MDD 10 DROPS	Sore throat, hoarseness
	Miralax	17gm PO qday prn MDD 17 GM	Stomach distress
	Bacitracin topical	1 Application to open areas BID PRN	OPEN AREAS, WOUNDS
	Bactine topical	1 Application PRN	Open areas, wounds

Allergies

Please list any allergies or sensitivities the camper has. This includes medication and food allergies.

Allergy Reaction

____________________ ____

____________________ ____

____________________ ____

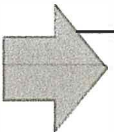
(You MUST contact us to discuss the food allergies. Please email campcook@threebhut.com.)

Camper's Current Medication Regimen

Please bring original bottles w/ correct labels. You may bring a pill box but the bottles must accompany it.

List current medications and over the counter medications to administer during camp. Include vitamins, herbs and supplements. Your physician's signature is required for the camp nurse to administer medications to your child.

Medication Name	Route	Dosage	Frequency (circle all that apply)
____________________	________	________	Morning Afternoon Evening Bedtime
____________________	________	________	Morning Afternoon Evening Bedtime
____________________	________	________	Afternoon Morning Evening Bedtime



Signature of Licensed /Certified Health Care Provider______________________________ Title______________

Phone Number __________________________Date____________________

Return completed forms & check made out to ABA Camp to: Caleb & Jen Clark 56 Margaret St. Saranac Lake, NY 12983