

## Adirondack Baptist Camp 2023

Registration due July 31st

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.**

<u>LHCP Order Yes or No</u>	<u>Medication Name</u>	<u>Comments</u>	
	Acetaminophen	325mg mg PO q4 hrs pm MDD 3000 mg	Pain, discomfort, fever
	Ibuprofen	200mg mg PO q4 hrs pm MDD 2400 mg	Pain, discomfort, fever
	Diphenhydramine HCL	25mg mg PO q4 hrs pm MDD 150 mg	Itching, congestion
	Cough drops/Tums	PO q2 hrs pm MDD 10 DROPS	Sore throat, hoarseness
	Miralax	17gm PO qday pm 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](mailto: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.

<u>Medication Name</u>	<u>Route</u>	<u>Dosage</u>	<u>Frequency (circle all that apply)</u>
_____	_____	_____	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