Foundation for Dreams Inc, and Dream Oaks Camp

Physical and Medication Administration Form A-1

(This form must be completed by your child's parent/guardian)

Medications will not be administered, unless they are approved by your health care provider (FORM A-2) and, if necessary, any changes in medication information after submission of this form needs to be documented using (FORM B). It's important that you follow the guidelines *exactly*. All campers, **regardless of age or level of independence,** will have medications administered by the Camp Nurse.

PRESCRIPTION MEDICATION

- All prescription medications require permission for administration by your health care provider.
- All products **must** be in their **original container.**

NON-PRESCRIPTION MEDICATION / SUPPLEMENTS/HERBS

- All non-prescription medications require permission for administration by your health care provider.
- All products **must** be in their **original container.**

ADDITIONAL REQUIREMENTS

- Medication Administration Changes – FORM B
  - Form B will need to be submitted **only** if there are any changes in medication between the time the health care provider originally signs this document (FORM A-1) and the start of the camp session.
  - If medications that have changed are essential for your child's health, we are not permitted to admit them to camp until proper documentation is provided.
- All medications **must** be delivered…
  - in the **current** prescription bottle, with labels that are **clear** to read, and with **only** the number of doses needed during camp plus 1-2 extras. Anything more may be sent home with you at check-in.

***We are unable to accept any Prescription medication/ Non-prescription medication / Supplements any other way*.**

PLEASE PROVIDE THE FOLLOWING TO THE NURSE AT CHECK-IN:

- Medications in their original containers, and only the number of doses needed for camp, in a Ziploc bag labeled with the camper's first and last name.
- Please bring Form B completed, as needed for any recent medication changes

Parent/Legal Guardian Permission to Obtain Medical Treatment

The undersigned hereby consents to the Participant receiving medical treatment that may be deemed advisable in the event of injury, accident and/or illness while attending Dream Oaks Camp, and the undersigned further assumes liability for all medical expenses and all other damages and expenses resulting from any injury, accident and/or illness in connection with a Foundation for Dreams or Dream Oaks Camp sponsored activity and/or event.

Printed Name of Parent/Legal Guardian: _____

Parent/Legal Guardian Signature: _____ **Date**: _____

Parent/Legal Guardian Phone Number(s): _____

Foundation for Dreams Inc, and Dream Oaks Camp

Dream Oaks Camp - 16110 Dream Oaks Place, Bradenton, Florida 34212
Phone: 941-746-5659 Fax: 941-745-1409

Physical and Medication Administration Form A-2

(This form must be completed by your child's physician)

Name of Camper: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **Temp:** _____ **Pulse:** _____ **Resp:** _____ **BP:** _____

Immunizations up to date: Yes ☐ No ☐ **Allergies:** _____

Diagnosis/Significant Health History: _____

Recent Hospitalization or Surgery: _____

Any limitations for participation: _____

Does this camper have a diagnosis, such as Atlantoaxial Instability or any other, that will prevent him/her from participating in any activities such as climbing, horseback riding, or outdoor activities? □ Yes □ No

If yes, please explain: _____

☐ This child **MAY NOT** participate in HORSEBACK RIDING. (Please check if this applies.)

Health Care Provider approval for administration of the following

Prescription and Non- Prescription Medication (including supplements and herbs):

(Additional boxes for medications are located on the back side of this form)

Name of Medication: Dosage & Frequency: Route: Purpose:	Name of Medication: Dosage & Frequency: Route: Purpose:
Name of Medication: Dosage & Frequency: Route: Purpose:	Name of Medication: Dosage & Frequency: Route: Purpose:

Camp nurse may administer age/weight appropriate dose of the medications listed below.

Ibuprofen (Motrin/Advil)	□ Yes	□ No	Milk of Magnesia	□ Yes	□ No
Acetaminophen (Tylenol)	□ Yes	□ No	Triple Antibiotic Ointment (Neosporin)	□ Yes	□ No
Hydrocortisone Cream	□ Yes	□ No	Antacid (Tums/Mylanta)	□ Yes	□ No
Diphenhydramine (Benadryl)	□ Yes	□ No	Pepto Bismal	□ Yes	□ No
Dulcolax or Bisacodyl tabs	□ Yes	□ No	Sunscreen	□ Yes	□ No
Glycerin suppository or Enema	□ Yes	□ No	Anti-diarrhea (Loperamide/Immodium)	□ Yes	□ No
Epipen (Allergic Reactions)	□ Yes	□ No			

Health Care Provider Approval: (**This form must be completed by your child's physician)**

I have examined this camper and find him/her to be in the satisfactory physical condition and capable of active participation in Dream Oaks Camp programs. I approve the administration of the above prescription/non-prescription medication/supplements. Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies including riding. I understand that Prospect Riding Center will weigh the medical information given against the existing precautions and contraindications.

Printed Name of Health Care Provider: _____

Health Care Provider Signature: _____ **Date:** _____

Health Care Provider Office *Phone* Number: _____ **Fax Number:** _____

Health Care Provider Office Address: _____

FOUNDATION FOR DREAM Foundation for Dreams Inc, Dream Oaks Camp –

16110 Dream Oaks Place, Bradenton, Florida 34212

Phone: 941-746-5659 Fax: 941-745-1409S, INC AND DREAM OAKS CAMP

PHYSICAL and MEDICATION ADMINISTRATION FORM A-3

Please use this form for medication that may have not been able to fit on the front side of Form A-2

Name of Medication: Dosage & Frequency: Route: Purpose:	Name of Medication: Dosage & Frequency: Route: Purpose:
Name of Medication: Dosage & Frequency: Route: Purpose:	Name of Medication: Dosage & Frequency: Route: Purpose:
Name of Medication: Dosage & Frequency: Route: Purpose:	Name of Medication: Dosage & Frequency: Route: Purpose:
Name of Medication: Dosage & Frequency: Route: Purpose:	Name of Medication: Dosage & Frequency: Route: Purpose:
Name of Medication: Dosage & Frequency: Route: Purpose:	Name of Medication: Dosage & Frequency: Route: Purpose:

Form B

Dream Oaks Camp Doctor Approval for

Additional and/or Revised Administration Instructions for Medications

(To be filled if a camper has additional medications or if the current dispensing instructions differ from those given in the Dreams Oaks Camp Medical Form A-1 signed earlier or if the instructions differ from the label on the prescription bottle.)

All items listed below are to be presented in the ORIGINAL package/ bottle, placed in a clear zip-lock bag and labeled with the child's full name.

Name of Camper: _____ Date: _____

Name of Parent/ Guardian: _____

ITEM 1	ITEM 2
Please check the appropriate box New Medication [ ] Revised Instructions [ ]	Please check the appropriate box New Medication [ ] Revised Instructions [ ]
Name of Medication:	Name of Medication:
Dosage of Frequency:	Dosage of Frequency:
Route:	Route:
Purpose:	Purpose:

Parent Name: _____

Signature: _____ Date: _____

Name of Prescriber/ Physician: _____

Phone: _____ Fax: _____

Signature of Prescriber/ Physician: _____ Date: _____