



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

Email to: registration@foundationfordreams.org

Physical and Medication Administration Form A-1

(This form must be completed by the child's parent/legal 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-2) 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.

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): _____



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

Check here if additional meds are listed on second page

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

- | | | | |
|-------------------------------|--|--|--|
| Ibuprofen (Motrin/Advil) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Milk of Magnesia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Acetaminophen (Tylenol) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Triple Antibiotic Ointment (Neosporin) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hydrocortisone Cream | <input type="checkbox"/> Yes <input type="checkbox"/> No | Antacid (Tums/Mylanta) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diphenhydramine (Benadryl) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pepto Bismol | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dulcolax or Bisacodyl tabs | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sunscreen | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glycerin suppository or Enema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anti-diarrhea (Loperamide/Imodium) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| EpiPen (Allergic Reactions) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Orajel | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Antifungal Cream (Tinactin) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sting Ease/Sting relief Pads | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Robitussin | <input type="checkbox"/> Yes <input type="checkbox"/> No | Midol | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diaper Balm (Desitin) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Zantac 75 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anusol Cream | <input type="checkbox"/> Yes <input type="checkbox"/> No | Preparation H | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Caladryl/Benadryl Cream | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glucose Tablets | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Saline gtts or Visine gtts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sudafed | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Throat Lozenges | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chloraseptic Spray | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Solarcaine Spray | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vagasil Cream | <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

PHYSICAL and MEDICATION ADMINISTRATION FORM A2 Continued

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:
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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 Dream Oaks Camp Medical Form A-2 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	Please check the appropriate box
<input type="checkbox"/> New Medication	<input type="checkbox"/> New Medication
<input type="checkbox"/> Revised Medication	<input type="checkbox"/> Revised Medication
Name of Medication:	Name of Medication:
Dosage of Frequency:	Dosage of Frequency:
Route:	Route:
Purpose:	Purpose:

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: _____