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: registeration@foundationfor dreams.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): _____

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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: 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.

Check here if additional meds are listed on second page ☐

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 Bismol	□ Yes	□ No
Dulcolax or Bisacodyl tabs	□ Yes	□ No	Sunscreen	□ Yes	□ No
Glycerin suppository or Enema	□ Yes	□ No	Anti-diarrhea (Loperamide/Imodium)	□ 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: _____

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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:
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:

***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: ____

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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 Dreams 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 ☐ New Medication ☐ Revised Medication Name of Medication: Dosage of Frequency: Route: Purpose:	Please check the appropriate box ☐ New Medication ☐ Revised Medication Name of Medication: Dosage of Frequency: Route: 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: _____