



## 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 |
| Orajel                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vagisil Cream                          | <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 |  |  |

**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 Dreams, Inc.**

Phone: 941-746-5659 Fax: 941-745-1409

Email: [registration@foundationfordreams.org](mailto:registration@foundationfordreams.org)

**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:
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**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: Registration@foundationfordreams.org

**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 <input type="checkbox"/> New Medication <input type="checkbox"/> Revised Medication Name of Medication: Dosage of Frequency: Route: Purpose:	Please check the appropriate box <input type="checkbox"/> New Medication <input type="checkbox"/> 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: \_\_\_\_\_