2021 STAFF EXAM/MEDICATION FORM

73 East Valley Brook Road
Long Valley, New Jersey 07853
Phone: (908) 876-3429
Fax: (908) 876-4635
info@MeadowbrookDayCamp.com

IMPORTANT!

- ∇ All Staff must have a completed health form based on a physical exam performed on or after **4/30/20.**
- ∇ This form must be signed by a **PHYSICIAN** and returned to Meadowbrook within 60 days of being hired. No Staff will be permitted to work without this form.

Name: ______________________________ Date of Birth: ______________

The above named individual was examined in my office on this date: ________________

Gender: _____________ BP: ___________ Height: _________ Weight: _________

In my opinion, this individual ☐ is ☐ is not able to participate in an active program.

This individual is under my care for the following condition(s): ____

ALLERGIES: *Known Allergies:*

Food(s): _____________________________ Reaction ___________________

Medicine(s) ___________________________ Reaction ___________________

Other ________________________________ Reaction ___________________

NOTE: Allergy Action Plan Form **MUST** be submitted with instructions for the treatment of an allergic reaction.

MEDICATIONS: Prescription medications must be in their original container with printed pharmacy & MD instructions and be brought to Camp by the Parent/Legal Guardian or given to a Meadowbrook Staff Member. All medications must remain in the Meadowbrook Nurse's Office at all times. *Permission is granted to Meadowbrook Day Camp personnel to administer the following medication(s)*:

Medication Name: ______________________________ Dose: _______________ Frequency: _____________

Reason for Medication: ___________________________ Begin on: ___/___/___ End on: ___/___/___

Possible Side Effects: ____________________________ Other Instructions: ___________________________

Medication Name: ______________________________ Dose: _______________ Frequency: _____________

Reason for Medication: ___________________________ Begin on: ___/___/___ End on: ___/___/___

Possible Side Effects: ____________________________ Other Instructions: ___________________________

OVER-THE-COUNTER MEDICATIONS (check all that apply): *In the event of a minor medical emergency or illness, the Camp Nurse has my permission to administer the following over-the-counter medications according to the label instructions, at their discretion:*

- ☐ Acetaminophen (Tylenol) *for discomfort, pain, fever*
- ☐ Cough Drops *for irritated throat or cough*
- ☐ Midol/Pamprin *for menstrual pain (if applicable)*
- ☐ Tums / Pepto Bismol *for upset stomach*
- ☐ Antihistamine (Claritin) ***For** allergy symptoms and hives.*
- ☐ Diphenhydramine (Benadryl) *for allergic reactions, hives, severe itching*
- ☐ Naproxen Sodium (Aleve) *for pain relief*
- ☐ Zanfel *for poison ivy*
- ☐ Cepacol lozenges *for sore throat*
- ☐ Ibuprofen (Advil/Motrin**)** *for discomfort, pain, fever*
- ☐ Orajel *for toothache, dental pain*
- ☐ Cortisone Cream/Ointment *for skin rash on unbroken skin, insect bites*
- ☐ Medicaine *for bee stings*
- ☐ Triple Antibiotic Ointment *for minor wounds*

IMMUNIZATION HISTORY: ***Please attach a the Staff Member's Immunization Record.***

Physician's Name ___________________________________

Physician's Phone # _________________________________

Physician Office Stamp

SIGN HERE

Physician Signature _________________________________ Date ____________