



Tri-Mount Scout Reservation

Rip Van Winkle Council Boy Scouts of America
75 Pine St. Kingston, NY 12401

845-339-0846
Fax 845-339-1168

TO: Unit Leaders/Parents:
From: Doug Whitaker, Camping Vice President
RE: Personal Standing Orders
DATE: March, 2007

Leaders/Parents,

As you may be aware, this form is in response to following the guidelines that the New York Health Department has requested. Here is an attached revised form. We have contacted our Health Department and Camp Physician to get input on creating this form. Only those medications listed will be available from the Camp.

Please make copies and get them to your youth. (We will have extra copies available at the office.)

This form must accompany the camper's physical.

This form must be completed yearly (12 months).

Each form **MUST BE SIGNED BY THE YOUTHS HEALTH CARE PROVIDER AND GUARDIAN**

If the Scout needs other over the counter medications that they are bringing to camp, they need to be placed in a zip lock bag with the Scouts name, Troop #, Camp Site and written on the Personal Standing Order form.

NOTES to help you fill out the form. For example:

Q 30 min to 1 hr prn for diarrhea - (Take every 30 minutes to 1 hour as needed for diarrhea)
(no>8 doses/24 hr) - (No more then 8 doses in 24 hours)

- Q = Every
- prn = As needed
- no>8 doses/24 hr = No more then 8 doses in 24 hours.

Please bear with us as we try to follow suggestions from the Health Department and our Physicians. We are looking out for the safety of our campers. If any guardian objects to their child receiving any of the listed medications, have that guardian write that on the form. I.e. (do not give my child any medications with out contacting his guardian)

Any questions please call the Council Office at 845 339-0846

HEALTH, MEDICAL AND BSA FORMS - NON RETURN NOTICES **USE ONLY COPIES**

Any "Personal Health & Medical Records", Individualized orders, BSA Class 1, Class 2, Class 3, Philmont or Jamboree Health and/or Medical forms) used at camp will not be returned to the participant at the conclusion of the event. The medical forms will be stored after the event and will not be able to access them for later events. Only copies of the other forms should be used since these records will not be returned after the event.

Camp Tri-Mount / Day Camp / Extended Activities

INDIVIDUALIZED ORDERS for: Name _____ Unit # _____

DOB: _____ Weight: _____ Week of Camp _____ Campsite _____

To Physicians: We know how valuable your time is and know that you also appreciate the increasing complexities we are facing at camp in dealing with camper's medical needs. We would appreciate your filling out this form to facilitate the treatment of our camper who is your patient. Please indicate the medications you would want (or not want) dispensed by our medical staff to the camper if needed. Please complete in the spaces provided for all medications the camper will bring to camp including prescriptions and over the counter medications. Thank you for helping us with the completion of this form.

Drug Name	Route	Dosage	Schedule And Indications	Health Care provider order	Comments
Tylenol		Per label instructions by age-weight	Q 4 hr prn for pain or fever > _____ ?F	Yes No	
Ibuprofen		Per label instructions by age-weight	Q 6 hr prn for pain or fever > _____ ?F	Yes No	
Pepto-Bismol		Per label instructions by age-weight	Q 30 min to 1 hr prn for diarrhea (no>8 doses/24 hr)	Yes No	
Benadryl		Per label instructions by age-weight	Q 4-6 hr prn for temporarily allergic reactions	Yes No	

If the Scout needs other over the counter (OTC) medications that they are bringing to camp, they need to be in their original packaging and placed in a zip lock bag with the Scouts name, Unit #, Camp Site / Location

				Yes No	
				Yes No	
				Yes No	

Prescription Medications (Please complete with patient's current regimen for both scheduled and prn medications. Use 2nd page if needed)

Drug Name	Route	Dosage	Schedule And Indications	Health Care provider order	Comments
				Yes No	
				Yes No	
				Yes No	
				Yes No	

Camper's Health Care Provider Name: _____ Phone # _____

Signature: _____ Date: _____

Parents Note: Any medications (prescription or over the counter) your child brings to camp must be given to the camp health care staff at registration and must be in the original packaging with the following information on it: Name of medication Name of person to receive the medication Expiration date Name of Physician (for prescription medications only) Directions for dispensing. Please place all medications for a given camper in a zip lock type bag with the camper's Name and Unit number on the bag.

Signature of parent or guardian _____ Date: _____