

2026 PHYSICIAN & MEDICATION FORM



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

IMPORTANT!

- ▽ All Staff must have a completed health form based on a physical exam performed on or after **4/30/25**.
- ▽ This form must be signed by a **PHYSICIAN** and returned to Meadowbrook within 30 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: _____ (The Exam Date Must Be Provided)

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 ADMINISTERED DURING THE CAMP DAY: Prescription medications must be in their original container with printed pharmacy & MD instructions, 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

☐ Zanafel
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

☐ Medicaaine
for bee stings

☐ Triple Antibiotic Ointment
for minor wounds

Please provide the above patient with a copy of their immunization records.

Physician's Name _____

Physician's Phone # _____

Physician Signature _____ Date _____

Physician Office Stamp