



UPWARD BOUND CAMP
PERSONAL STANDING ORDER

P.O. Box C, Stayton OR 97383
Phone (503) 897-2447 Fax (503) 897-4116
Email: camp@upwardboundcamp.org

OFFICE USE ONLY
Received by: _____
Date received: _____

This form MUST be on file prior to camp attendances and will remain active for 2 years from date received.

PERSONAL STANDING ORDER:

At times, it may become necessary to treat minor ailments with over the counter medications. In these cases, we refer to the Camp Physician's Standing Orders.

Please see the list of medications below that have been approved by the camp physician for use at camp. Indicate if these are acceptable for your camper under the direction of Upward Bound Camp Standing Orders.

MEDICATION	YES	NO
ALOE VERA GEL		
CALAMINE LOTION/CALADRYL		
BENADRYL OR GENERIC EQUIVALENT (FOR ALLERGIC REACTIONS AND SLEEP)		
EPINEPHRINE (FOR SERIOUS ALLERGIC REACTION)		
HYDROCORTISONE CREAM		
SUN BLOCK		
INSECT SPRAY		
ANTIBIOTIC OINTMENT (I.E. NEOSPORIN)		
ADVIL/IBUPROPHEN		
TYLENOL OR GENERIC EQUIVALENT		
MOTRIN OR GENERIC EQUIVALENT		
ASPIRIN		
IMODIUM OR EQUIVALENT (FOR DIARRHEA)		
MILK OF MAGNESIA		
MAALOX		
EMATROL OR GENERIC EQUIVALENT (FOR NAUSEA)		
TUMS		

CAMPER INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____
 Gender (check one): Male Female Other Birthdate: _____ MM/DD/YY
 Name of person completing this form: _____ Length of time known camper: _____
 Phone: _____ Email: _____

I AUTHORIZE UPWARD BOUND CAMP TO ADMINISTER THE MEDICATIONS LISTED ON THE CAMPER MEDICATION RECORD PAGE ACCORDING TO THE MANUFACTURERS' WRITTEN INSTRUCTIONS. THE MEDICATION INFORMATION GIVEN TODAY SUPERSEDES ANY PREVIOUS MEDICATION INFORMATION GIVEN. I AUTHORIZE UPWARD BOUND CAMP TO ADMINISTER ANY OF THE ABOVE MEDICATIONS INDICATED "YES" ACCORDING TO THE "CAMP STANDING ORDERS" AS NECESSARY FOR MINOR AILMENTS.

Camper/Guardian Signature _____ Date: _____
 Camper/Guardian Name Printed _____ Phone: _____