ROBERTS WESLEYAN UNIVERSITY

Health Care Provider Consent
Academic Summer Camps 2026

Please print this form and take to your child's Health Care Provider for completion. *Return the completed form to the Camp Coordinator any of the following ways:*

- Email a scanned copy of the completed forms Smith Martha@Roberts.edu
- Fax completed form to: (585) 594-6084
- Mail to: Roberts Wesleyan University
  C/O Martha Smith – Summer Camps
  2301 Westside Drive
  Rochester, NY 14624

Under New York State Law, campers cannot be given ANY medications without the signature of a Health Care Provider (HCP). Please have your HCP list any prescription medications and over-the-counter (OTC) medications below. Current medications MUST be brought in the **original container** with instructions and name of the medication. *"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. The Camp **does not** stock OTC Medications. All medications, including OTC, need a patient-specific order. If the child is able to do so, he/she may self-administer medicine under supervision, in the Camp Nurse's Office.*

Camper's Name: _____ **Camper's DOB:** _____ **Camper's Gender:** _____

Will this camper take medicine during the camp week(s)? ☐ Yes ☐ No

Name of Medication	When is it given	Amount or dose given	How is it given
	☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other:___		
	☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other:___		
	☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other:___		

With an HCP approval, the following NON-Prescription medications may be taken during the camp week(s). The OTC Products will be dosed according to the package instructions unless otherwise noted. You must bring your own medication, in its original container, labeled with the camper's name.

OTC Products	HCP Approval	
Acetaminophen (i.e. Tylenol)	☐ Yes	☐ No
Ibuprofen (i.e. Advil/Motrin)	☐ Yes	☐ No
Antihistamine (i.e. Benadryl)	☐ Yes	☐ No
Antacid Tablets (i.e. Tums)	☐ Yes	☐ No
Calamine, Caladryl or Hydrocortisone Cream	☐ Yes	☐ No
Antibiotic Ointment	☐ Yes	☐ No

Please attach a current copy of the child's IMMUNIZATION RECORDS or fill in the dates below:

Diphtheria____Haemophilus Influenza Type b____Tetanus Booster____Poliomyelitis____ Varicella (chickenpox)____Measles Vaccine____Rubella (MMR)____Mumps____Hepatitis b____

Health Care Provider Signature: _____ **Date:** _____

Health Care Provider's Name (PRINT): _____ **Phone:** (___) _____