

CAMPER HEALTH CARE RECOMMENDATIONS - FORM 2

To Parent(s)/Guardian(s): Complete the top section and give this form and a copy of your completed Camper Health History Form (Form 1) to your child's health care provider for review.

Camper Name:

Camper Name: _____
Last First

Male Female Date of Birth: _____ Age on arrival at camp: _____
Month/Day/Year

Home Address: _____

Custodial Parent/Guardian Telephone: _____

Medical Personnel: Please review the Camper Health History Form (Form 1) and complete all remaining sections of this form (Form 2). Attach additional information if needed.

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. **Medical personnel: Cross out those items the camper should not be given.**

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Phenylephrine (Sudafed PE)
- Pseudoephedrine (Sudafed)
- Chlorpheniramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimite)
- Calamine lotion
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Calamine lotion
- Aloe

Physical exam performed today: Yes No

If No, date of last physical: _____
Month/Day/Year

ACA accreditation standards require physical exam within last 12 months.

Weight: _____ lbs. **Height:** _____ ft. _____ in. **BP:** _____ / _____

Allergies: No Known Allergies

- To foods, list:
 - To medications, list:
 - Environmental (insect stings, hay fever, etc.), list:
 - Other allergies, list:
- Describe previous reactions.

Diet, Nutrition: Eats a regular diet. Has a medically prescribed meal plan or dietary restrictions: (describe below)

The camper is undergoing treatment at this time for the following conditions: (describe below) None

Medication: No daily medications. Will take the following prescribed medication(s) while at camp: (name, dose, frequency, describe below)

Other treatments/therapies to be continued at camp: (describe below) None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? Yes No If yes, what do you recommend? (describe below, attach additional information if needed)

"I have reviewed the Camper Health History Form, and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)"

Name of licensed provider (please print) _____ Signature _____ Title _____

Office Address: _____

Telephone: _____ Date: _____

Last

First

Camp Session: