CAMPER HEALTH-CARE RECOMMENDATIONS by LICENSED MEDICAL PERSONNEL FORM 2

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Mail this form to the address below by _____ (date)

***To Adult Camper or Parent(s)/Guardian(s): Complete this section** and give **this form (FORM 2)** and **a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1)** to your health-care provider for review. (camper under 18 years old, a parent/guardian must compete this section)*

Dates will attend camp: from _____to_____
Month/Day/Year Month/Day/Year

Camper Name:_____
First Middle Last

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

Camper home address: _____

_____
City State Zip Code

Phone:(_____) _____

Adult Camper/***Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.***

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)
Chlorpheneramine maleate
Guaifenesin
Dextromethorphan
Diphenhydramine (Benadryl)
Generic cough drops
Chloraseptic (Sore throat spray)
Lice shampoo or scabies cream (Nix or Elimite)
Calamine lotion
Bismuth subsalicylate (Pepto-Bismol)
Laxatives for constipation (Ex-Lax)
Hydrocortisone 1% cream
Topical antibiotic cream
Calamine lotion
Aloe

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.

Physical exam done today: Yes or No (**If "No," date of last physical**: _____)
Month/Day/Year

ACA accreditation standards specify physical exam within last 12 months.

Weight: _____ lbs Height: _____ft_____in Blood Pressure_____/_____

Allergies: ☐ No Known Allergies To foods

☐ ***(list):***

☐ To medications: ***(list):***

☐ To the environment ***(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? No Yes

If you answered "Yes" to the question above, what do you recommend? ***(describe below—attach additional information if needed)***

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper and/or 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:_____

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