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: _____ (Last) _____ (First)

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

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)
- 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

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: _____

Camper Name: Last First

Camp Session: