MEDICAL RECOMMENDATIONS FORM FOR CAMPERS

PLEASE MAIL THIS FORM TO ADDRESS INDICATED ON INSTRUCTIONS BY MAY 1st. FORM TO BE COMPLETED BY MEDICAL PERSONNEL.

Name of Camper: _____ Sex: ☐ Female ☐ Male
First Middle Last

Birthdate: _____ Age Upon Arrival at Camp: _____ Dates attending Camp: From _____ to _____
Month/Day/Year Month/Day/Year Month/Day/Year

Camper Home Address: _____
Street Address City State Zip Code

Parent/Guardian Phone Number: (_____)_____

########## **STOP HERE. THE REST OF THIS FORM TO BE COMPLETED BY MEDICAL PERSONNEL**. ##########

The following non-prescription medications are commonly stocked in camp Health Centers and are used on as AS NEEDED basis to manage illness and injury.

MEDICAL PERSONNEL:
Please CROSS OUT those items the Camper should NOT be given.

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Chlorpheneramine maleate
Guaifenesin
Dextromethorphan
Diphenhydramine (Benadryl)
Generic Cough Drops
Chloraseptic (Sore throat spray)
Lice Shampoo or scabies cream (Nix or Elimite)
Calamine lotion
Hydrocortisone 1% cream
Topical antibiotic cream
Calamine lotion
Aloe

MEDICAL PERSONNEL: *Please review the HEALTH HISTORY FORM and complete all remaining sections of this Form, attaching additional information as needed.*

Physical Exam Today: ☐ Yes ☐ No Date of Last Physical: _____

Weight: _____lbs Height: ____ ft ____in Blood Pressure ____/____

Allergies:

_____ No known allergies.

_____ Camper has an allergy to: ☐ Food ☐ Medicine ☐ Environment (insect stings, hay fever, etc.) ☐ Other

Please list allergies and describe previous reactions:

_____

Diet/Nutrition:

This Camper ☐ Eats a Regular Diet ☐ Has a medically prescribed meal plan or dietary restrictions. Please describe:

_____

The Camper is undergoing treatment at this time for the following condition: Please describe:

_____

Medication:

_____ No daily medications

_____ Will take the following prescribed medication(s) while at camp:

Please describe (name, dose, frequency):

_____

_____

Other treatments/therapies to be continued at camp: Please describe:

_____

Do you feel that the Camper will require limitations or restrictions to activity while at camp:

☐ No ☐ Yes. Please describe: _____

I have reviewed the HEALTH HISTORY FORM and 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: _____

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