

FFGC WEKIVA YOUTH CAMP MEDICAL RECOMMENDATION FORM FOR CAMPERS

PLEASE SCAN AND EMAIL THIS FORM TO THE CAMP REGISTRAR AT wycregistrar@gmail.com OR USE THE EMAIL

LINK PROVIDED FOR THE ONLINE DOCUMENT UPLOAD CENTER.

Name of Camper: _____ Gender: _____
First Middle Last

Birthdate: _____ Age Upon Arrival at Camp: ____ Dates Attending Camp: _____ to _____
MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY

Camper Home Address: _____
Street Address City State Zip Code

Parent/Guardian Phone Number: (____) _____

PLEASE STOP HERE. THE REMAINDER OF THIS FORM TO BE COMPLETED BY MEDICAL PERSONNEL.

MEDICAL PERSONNEL: Please complete the remainder of this form and attach any additional information as needed.

Physical Exam Today: __ Yes __ No If not, date of last physical (must be within one year of Camp attendance dates): _____
MM/DD/YYYY

Weight: _____ lbs. Height: ____ ft ____ in. Blood Pressure: ____ / ____

Allergies:

___ No known allergies
___ Camper has allergy to : ___ Food ___ Medicine ___ Environmental (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(s): _____

Medication:

___ No daily medications
___ Will take the following prescribed medication(s) while at camp: Please describe (name, dosage, frequency):

Other treatment/therapies to be continued at camp: Please describe: _____

Do you feel that the camper will require limitations or restrictions to activities while at camp? ___ No ___ Yes If yes, please describe:

The following non-prescription medicines are stocked in the camp clinic and are used on an AS NEEDED basis to manage illness and injury.

MEDICAL PERSONNEL: Please **CROSS OUT** the items the camper should **NOT** be given.

Tylenol (Acetaminophen) Ibuprofen (Advil, Motrin) Claritin (Loratadine) Zyrtec (Ceritizine) Cough Syrup (Guaifenesin or Dextromethorphan) Benadryl (Diphenhydramine) Chloraseptic (Sore throat spray) Lice shampoo Calamine Lotion Cortisone cream Benadryl cream Topical antibiotic cream (Neosporin/ Triple antibiotic ointment) Aloe Eye drops/artificial tears Eye drops/vasconstrictor Children's Rolaids/Tums (Calcium Carbonate) Maalox (Aluminum hydroxide, Magnesium hydroxide) Emetrol (dextrose, levulose, phosphoric acid) Immodium (Loperamide) Miralax (Polyethylene glycol) Muscle Rub/Bengay

FOR THE PROVIDER: I have reviewed 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): _____ Licensed Provider's Signature: _____
Title: _____ Office Address: _____
Telephone: _____ Date: _____