FFGC WEKIVA YOUTH CAMP MEDICAL RECOMMENDATION FORM FOR VOLUNTEERS

PLEASE SCAN AND EMAIL THIS FORM TO THE FFGC CHAIRMAN AT WEKIVACHAIRMAN@GMAIL.COM

Name of Volunteer: _____ Gender: ____
First Middle Last

Birthdate: _____ Dates Volunteering at Camp: _____ to _____
MM/DD/YYYY MM/DD/YY MM/DD/YY

Volunteer Home Address: _____
Street Address City State Zip Code

Volunteer 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/YY

Weight: _____lbs. Height: ___ ft ___ in. Blood Pressure: _____/_____

Allergies:

___ No known allergies

___Volunteer has allergy to : ___ Food ___ Medicine ___ Environmental (insect stings, hay fever, etc.) ___ Other

Please list allergies and describe previous reactions: _____

_____

Diet/Nutrition:

This Volunteer ___ Eats a regular diet ___ Has a medically prescribed meal plan or dietary restrictions

Please describe: _____

The Volunteer 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 Volunteer 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 Volunteer should NOT be given.

Tylenol (Acetaminophen) Ibuprofen (Advil, Motrin) Sudafed (18+) 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/artifical tears Eye drops/vasconstrictor 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 Volunteer. It is my opinion that the Volunteer 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:** _____