

**CAMPER HEALTHCARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL FORM 2**

*Please Print All Information*

<p style="color: red; text-align: center;"><i>Return Completed Form by April 1st to</i></p> <p align="center"><b>Questions?</b> Call</p>	<p><u>To Parents(s)/Guardian(s):</u> Complete this section and give <b>this form (FORM 2)</b> and a copy of your <u>completed CAMPER HEALTH HISTORY FORM (FORM 1)</u> to your child's health-care provider for review.</p> <p>Dates will attend camp: ____/____/____ to ____/____/____  <small>Month Day Year Month Day Year</small></p> <p>Camper Name: _____  <small>First Name Middle Last</small></p> <p><input type="checkbox"/> M <input type="checkbox"/> F Birth Date: ____/____/____ Age on arrival at camp _____  <small>Month Day Year</small></p> <p>Camper Home Address: _____  <small>Street Address City State Zip Code</small></p> <p>Custodial parent(s)/guardian(s) telephone: (____) _____</p> <p align="center"><b>PARENT(S)/GUARDIAN(S) STOP HERE. REST OF FORM TO BE COMPLETED BY MEDICAL PERSONNEL.</b></p>
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<p>The following non-prescription medications are commonly stocked in our camp's Health Center and will be used on an <u>as needed</u> basis to manage illness and/or injury.</p> <p><u>Medical personnel:</u>  <b>CROSS OUT</b> those items the camper should <u>not</u> be given...</p> <p>Acetaminophen (Tylenol)  Aloe  Antibiotic cream, topical  Antihistamine/allergy medicine  Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)  Calamine lotion  Chlorpheniramine maleate  Dextromethorphan cough syrup (Robitussin DM)  Diphenhydramine antihistamine/allergy medicine (Benadryl)  Epinephrine  Generic cough drops  Guaifenesin cough syrup (Robitussin)  Hydrocortisone Cream  Ibuprophen (Advil, Motrin)  Ivy Dry  Laxatives for constipation (Ex-Lax)  Lice shampoo or cream (Nix or Elimite)  Phenylephrine decongestant (Sudafed PE)  Pseudoephedrine decongestant (Sudafed)  Silver Sulfadiazine  Sore throat spray  Tolnaftate</p>	<p><u>Physical exam done today:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, date of last physical ____/____/____)  <small>Month Day Year</small>  ACA accreditation standards specify physical exam within last 24 months.</p> <p>Weight ____ lbs Height ____ft ____ in Blood Pressure ____/____</p> <p><u>Allergies:</u> <input type="checkbox"/> No known allergies  <input type="checkbox"/> Food (<i>list</i>)  <input type="checkbox"/> Medicine (<i>list</i>)  <input type="checkbox"/> The environment (insect stings, hay fever, etc.) (<i>list</i>)  <input type="checkbox"/> Other (<i>list</i>)</p> <p><b>Describe previous reactions:</b></p>
<p><u>Diet, Nutrition:</u> <input type="checkbox"/> This camper eats a regular diet <input type="checkbox"/> Has a medically prescribed meal plan or dietary restrictions: (<b>describe below</b>)</p>	<p><b>This camper is undergoing treatment at this time for the following conditions: (describe below).</b> <input type="checkbox"/> None</p>
<p><u>Medication:</u> <input type="checkbox"/> No daily medications <input type="checkbox"/> Will take the following prescribed daily medication(s) while at camp. (<b>name, dose, frequency - describe below</b>)</p>	<p><b>Other treatments/therapies to be continued at camp: (describe below)</b> <input type="checkbox"/> None needed</p>

**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 FORMS (FORM 1), 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 \_\_\_\_\_  
Street Address City State Zip Code

Telephone (\_\_\_\_) \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_