|  |  |  |  |
| --- | --- | --- | --- |
|  | | ***To Parent(s)/Guardian(s): Complete this section*** *and give* ***this form (FORM 2)*** *and* ***a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1)*** *to your child’s health-care provider for review.*  Dates will attend camp: from July 22, 2023 \_to July 29, 2023  Month/Day/Year Month/Day/Year  Camper Name:  First Middle Last  Male Female Birth Date Age on arrival at camp  Month/Day/Year  Camper home address:  City State Zip Code  Custodial parent(s)/guardian(s) phone: ( ) ( )  ***Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.*** | Camper Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (For Camp Use) Cabin or Group\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (For Camp Use) Session Code(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  First Middle Last |
|  | | |
| 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) Chlorpheniramine maleate Guaifenesin Dextromethorphan Diphenhydramine (Benadryl) Generic cough drops  Chloroacetic (Sore throat spray)  Lice shampoo or scabies cream (Nix or Emilite) Calamine lotion  Bismuth subsalicylate (Pepto-Bismol) Laxatives for constipation (Ex-Lax)  Hydrocortisone 1% cream Topical antibiotic cream Calamine lotion  Aloe | ***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.*** | |
| **Physical exam done today:** Yes No (**If “No,” date of last physical**: ) Month/Day/Year  **ACA accreditation standards specify physical exam within last 12 months.** | |
| Weight: lbs. Height: ft in Blood Pressure\_ / | |
| **Allergies:** No Known Allergies  To foods ***(list):***  To medications: ***(list):***  To the environment ***(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?** 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 FORM (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 City State Zip Code  Telephone: ( ) Date: | | |
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CAMPER HEALTH-CARE RECOMMENDATIONS

by LICENSED MEDICAL PERSONNEL FORM 2

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

***Mail this form to the address below by JULY 1, 2018***

[***OR scan and email to info@camp4kids.org***](mailto:info@camp4kids.org)