Recommendations for Licensed Medical Personnel

FORM 2

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

american CAMP association®

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

**Camp Weed**
**11057 Camp Weed Pl.**
**Live Oak, FL 32060**

*To Parent(s)/Guardian(s): Complete this section and give this form (FORM 2) and to your child's health-care provider for review.* **Be prepared to discuss the Camper Health History form you filled out (or will fill out) online.**
**Dates will attend camp: from** _____ (Month/Day/Year) **to** _____ (Month/Day/Year)

Camper Name: _____ (First) _____ (Middle) _____ (Last)

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp _____

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.***

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)
- Chlorpheneramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimite)
- Calamine lotion
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Calamine lotion
- Aloe

*Medical Personnel: Please consult with parents concerning 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 the 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 consulted with parents about 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 Name _____ (First) _____ (Middle) _____ (Last)

(For Camp Use) Cabin or Group _____

(For Camp Use) Session Code(s): _____