

**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



**Due two weeks prior to arrival at camp.**

**Mail:** Pilgrim Lodge  
103 Pilgrim Lodge Lane  
West Gardiner, ME 04345  
**Fax:** 207-724-3732

**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 \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Camper Name: \_\_\_\_\_  
First Middle Last

Sex assigned at birth  Male  Female Birth Date \_\_\_\_\_  
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.**

**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 24 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:**

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
- 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

**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: \_\_\_\_\_

Camper Name

First

Middle

Last

(For Camp Use) Cabin or Group

(For Camp Use) Session Code(s):