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)** toyour 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.

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)
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Dextromethorphan cough syrup (Robitussin DM)
Sore throat spray
Generic cough drops
Calamine lotion
Mylanta (Antacid Liquid)
Dimetapp
Betadine
Triple Antibiotic Ointment
Swim Ear Drops / Auri-Dry
Saline Eye Drops
Tums
Immodium / Kaopectate
Clotrimazole / Lotrimin
Hydrocortisone 1%
Sore Throat Lozenges / Cepacol
Gluco-Tabs
Bacitracin (Double antibiotic ointment)
Miralax
Aloe Lotion
Sting Swabs (Benzocaine)

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, hayfever, 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: _____

Camper Name _____
First Middle Last
(For Camp Use) Cabin or Group _____ (For Camp Use) Session Code(s): _____