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| NORTHERN FRONTIER CAMPCAMPER HEALTH-CARE RECOMMENDATIONS by LICENSED MEDICAL PERSONNEL - FORM 2**Please log-in to your NF account, click on Additional Options, click on Document Center, then upload this and other documents.****Please have it completed before you arrive to camp.****If necessary this form can also be printed, signed, mailed, or handed in on arrival.****Note: This form is not necessary for any Father/Son camp sessions.** | ***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 toMonth/Day/Year Month/Day/YearCamper Name: First Middle Last Male � Female Birth Date Age on arrival at camp Month/Day/YearCamper home address: City State Zip CodeCustodial 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 |
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| 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) Guaifenesin Dextromethorphan Diphenhydramine (Benadryl) Generic cough dropsChloraseptic (Sore throat spray)Lice shampoo or scabies cream (Nix or Elimite) Bismuth subsalicylate (Pepto-Bismol) Laxatives for constipation (Ex-Lax) Calcium Carbonate (TUMS)Hydrocortisone 1% creamTopical antibiotic cream Calamine lotionAloeAllergy relief (Zyrtec, Claritin)ImmodiumMedicaine (for bee stings)Antigungal (cream, spray or powder)Swimmer’s Ear Drops | ***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 (Vaccine records, etc.).*** |
| **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:***
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| **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. |
| **Camper Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Dates will attend camp**: from \_\_\_\_\_\_\_\_\_\_\_(Month/Date/Year) to \_\_\_\_\_\_\_\_\_\_\_\_\_(Month/Date/Year)**Medication:**  This camper will not take any daily medications while attending camp. This camper will take the following daily medication(s) while at camp:"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper’s name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

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| Name of Medication | Date Started | Reason for taking it | When it is given | Amount or dose given | How it is given |
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| **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 CodeTelephone: ( ) Date:  |
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