NORTHERN FRONTIER CAMP

HEALTH HISTORY (PHYSCIAN)
FORM 2

Adapted by Northern Frontier from: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses.*

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.

To Parent(s)/Guardian(s): Complete this section and give this form (FORM 2) 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

☐ 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.

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.***

Pain and fever
Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Cold, cough, and congestion
Phenylephrine (Sudafed PE)
Pseudoephedrine (Sudafed)
Chlorpheneramine maleate
Guaifenesin
Dextromethorphan
Generic cough drops
Sore throat and mouth
Chloraseptic (sore throat spray)
Benzocaine (Medicaine)
Allergy (oral antihistamines)
Diphenhydramine (Benadryl)
Cetirizine (Zyrtec)
Loratadine (Claritin)
Levocetirizine (Xyzal)
Fexofenadine (Allegra)
Allergy (nasal and eye)
Fluticasone propionate (Flonase)
Triamcinolone acetonide (Nasacort)
Olopatadine (Pataday)

Stomach and digestion
Bismuth subsalicylate (Pepto-Bismol)
Loperamide (Imodium)
Calcium carbonate (Tums)
Laxatives (Ex-Lax, Miralax)
Motion sickness
Dimenhydrinate (Dramamine)
Skin, rash, and itch
Calamine lotion
Hydrocortisone 1% cream
Wound and burn care
Topical antibiotic cream (Neosporin)
Lidocaine 0.5% burn gel
Aloe
Fungal infections and infestations
Clotrimazole (Lotrimin)
Tolnaftate (Tinactin)
Lice shampoo or scabies cream (Nix or Elimite)

Medical Personnel: Please 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 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:

Diet, Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions: (describe below)

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The camper is undergoing treatment at this time for the following conditions: ***(describe below)*** ☐ None.

"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. New York State requires 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.***

Medication: ☐ No daily medications. ☐ Will take the following prescribed medication(s) while at camp: ***(name, dose, frequency—describe below)***

Name of Medication	Date started	Reason for taking	When it is given	Amount or dose given	How it is given
			__ Breakfast __ Lunch __ Dinner __ Bedtime Other:_____		
			__ Breakfast __ Lunch __ Dinner __ Bedtime Other:_____		
			__ Breakfast __ Lunch __ Dinner __ Bedtime Other:_____		
			__ Breakfast __ Lunch __ Dinner __ Bedtime Other:_____		
			__ Breakfast __ Lunch __ Dinner __ Bedtime Other:_____		
			__ Breakfast __ Lunch __ Dinner __ Bedtime Other:_____		

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 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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