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_____(date)

Trudy Boulter - Director
13123 East 16th Avenue - Box 580
Aurora, CO 80045
Fax: 720-777-7270

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.

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

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

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 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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