Camper Health History Form 2

Return this completed to the address below by June 1st.

Skyland Camp for Girls
P.O. Box 128
Clyde, NC 28721
Fax: 888-298-5711

Questions?
Call Skyland at 828-627-2470

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 _____ (Month/Day/Year) to _____ (Month/Day/Year)

Camper Name _____ (Last) _____ (First) _____ (Middle)

Birth Date _____/_____/_____ (Month/Day/Year) Age on arrival at camp _____years /_____months

Camper home address: _____

_____

Custodial parent(s)/guardian(s) phone: (_____) _____ (_____) _____

Parents/Guardians: STOP here. The rest of this form is completed by medical personnel

The following non-prescription medications are commonly stocked in camp Health Centers and are used on and 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

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)
(Requirements specify a physical exam within 12 months prior to arriving at camp)

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/on separate sheet)**

Current Treatment(s): 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: **(describe name, dose, frequency)**

Other treatment/therapies to be continued at camp **(describe below/on separate sheet)** ☐ None needed

Do you feel that the camper will require limitations or restrictions to camp activity while at camp? ☐ No ☐ Yes
(If you answered YES, what do you recommend? **(Describe below/on separate sheet)**

"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)

Camper Name (Last/First/M) _____

(For Camp Use Only) _____