|  |  |  |  |
| --- | --- | --- | --- |
| 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* |  | ***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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (  For Camp Use) Cabin or Group  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (For Camp Use) Session Code(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  First  Middle    Last |
| ***Mail this form to the address below by 06/20/25***  Robert Schuck  N6011 State RD 70  Winter, WI 54896  or to d5youthdirector@gmail.com |
|  |  |
| 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 | ***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, 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 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Copyright 2008 by American Camping Association, Inc. Rev. 2/07 LEE/EAW | | |