

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



Mail this form to the address below by \_\_\_\_\_ (date)

COA - Att. CHB  
909 E. North Ave.  
Milwaukee, WI 53212  
DUE at least 4 weeks before camp.

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 \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ (For Camp Use) Cabin or Group \_\_\_\_\_ (For Camp Use) Session Code(s): \_\_\_\_\_

CONVENIENT PHYSICALS AVAILABLE AT:



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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)          | Lice shampoo or scabies cream        |
| Ibuprofen (Advil, Motrin)        | (Nix or Elimite)                     |
| Phenylephrine (Sudafed PE)       | Calamine lotion                      |
| Pseudoephedrine (Sudafed)        | Bismuth subsalicylate (Pepto-Bismol) |
| Chlorpheniramine maleate         | Laxatives for constipation (Ex-Lax)  |
| Guaifenesin                      | Hydrocortisone 1% cream              |
| Dextromethorphan                 | Topical antibiotic cream             |
| Diphenhydramine (Benadryl)       | Calamine lotion                      |
| Generic cough drops              | Aloe                                 |
| Chloraseptic (Sore throat spray) |                                      |

**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 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 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: \_\_\_\_\_