

CAMPER HEALTHCARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL FORM 2

Please Print All Information

To Parents(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: ____/____/____ to ____/____/____
Month Day Year Month Day Year

Camper Name: _____
First Name Middle Last

M F Birth Date: ____/____/____ Age on arrival at camp _____
Month Day Year Month Day Year

Camper Home Address: _____
Street Address City State Zip Code

Custodial parent(s)/guardian(s) telephone: (____) _____

PARENT(S)/GUARDIAN(S) STOP HERE. REST OF FORM TO BE COMPLETED BY MEDICAL PERSONNEL.

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
 Food (*list*)
 Medicine (*list*)
 The environment (insect stings, hay fever, etc.) (*list*)
 Other (*list*)

Describe previous reactions:

Diet, Nutrition: This camper eats a regular diet Has a medically prescribed meal plan or dietary restrictions: (**describe below**)

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

Medication: No daily medications Will take the following prescribed daily 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 FORMS (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 Address City State Zip Code

Telephone (____) _____ Date ____/____/____