

**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

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

Due to camp by June 1st  
Camp Huntington  
56 Bruceville Road  
High Falls, New York 12440

**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.**

**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:**

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)
- Chlorpheniramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimate)
- Calamine lotion
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Calamine lotion
- Aloe

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