

Recommendations for Licensed Medical Personnel

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses



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

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

Medical Personnel: Please complete all remaining sections of this form. 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:

Middle
Last

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 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: _____

(For Camp Use) Cabin or Group _____
 (For Camp Use) Session Code(s): _____