

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  
Last

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): \_\_\_\_\_