

**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*

Please submit this form one of the following ways

1. Mail to 1624 W Front St, Blue Grass, IA 52726
2. Email to aclark@scottcountyfamily.org
3. Drop off at a Scott County Family Y branch
4. Bring to Camp check in.

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.**

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

Medical Personnel - Please review the camper's Health History Form (filled out by parent/guardian) and complete the remaining sections on this form.

**Physical exam done today:**  Yes  No (If "No," date of last physical: \_\_\_\_\_)  
Month/Day/Year

**ACA accreditation standards specify physical exam within 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: \_\_\_\_\_