

**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 \_\_\_\_/\_\_\_\_/\_\_\_\_