Recommendations for Licensed Medical Personnel

FORM 2

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

american CAMP association®

Mail this form to the address below by 05/19/2019 ***(date)***

The Barn at Spring Brook Farm
360 Locust Grove Rd
West Chester, PA 19382

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 _____ (Month/Day/Year) to _____ (Month/Day/Year)

Camper Name: _____ (First) _____ (Middle) _____ (Last)

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp _____

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 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:

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)***

Camp Geronimo does not carry over-the-counter medications. All medications to be adminstered must have a physician order.

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:_____

 Inc. Rev. 1/14 LEE/EAW

Camper Name First Middle Last

(For Camp Use) Cabin or Group _____

(For Camp Use) Session Code(s): _____