

**CAMPER HEALTH CARE RECOMMENDATIONS  
by LICENSED MEDICAL PERSONNEL FORM 2**

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

**Mail this form to the address below by \_\_\_\_\_ (date)**

**Carmel Valley Tennis Camp  
20805 Cachagua Road  
Carmel Valley, CA 93924**

**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 \_\_\_\_\_ 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 Eliceite)
- 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 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 last 24 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:** \_\_\_\_\_