

Physician Form

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

american **CAMP** association®

Camper Name: _____
First Middle Last
 Birth Date _____ Sex _____
 Custodial parent(s)/guardian(s) phone: (____) _____

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

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) | |

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

ACA accreditation standards specify physical exam within the 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? Yes No

If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)

"I have filled out all of the sections above 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: _____

Office Address

Street _____ City _____ State _____ Zip Code _____

Telephone: (____) _____ Date: _____



Camper Name _____
 (For Camp Use) Cabin or Group _____

