Recommendations for Licensed Medical Personnel

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 date)

Dunkley's Gymnastics Camp
22 Ayers Drive
Jericho, VT 05465

Complete this section and give this form 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

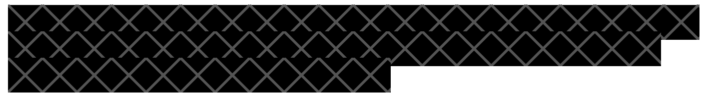
Custodial parent(s)/guardian(s) phone: (______)____________________ (______)______________________

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

Camper Name ______ First Middle Last

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)
- Chlorpheneramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimite)
- Calamine lotion
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Calamine lotion
- Aloe
- After Bite for mosquito bites
- Melatonin



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? ☐ No ☐ Yes

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

It is my opinion that this 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:____________________

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