Casowasco Camp & Retreat Center

Recommendations for Licensed Medical Personnel

FORM 2

Adapted from form developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Mail this form to the address below 3 weeks prior to the start of camp.

Casowasco Camp & Retreat Center
158 Casowasco Drive
Moravia, NY 13118

To Parent(s)/Guardian(s): Complete this section ONLY 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)

Gender: _____ Birth Date: _____ (month/day/year) Age on arrival at camp: _____

Camper home address: _____ (Street 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.

(for camp use) Camper Name: _____ (Last / First / Middle) _____ (for Camp Use) Program: _____ (for camp use) Rcv: _____

The following non-prescription medicines are stocked in the camp Health Center 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	Visine
Ibuprofen	Benadryl
Hydrogen Peroxide/Antiseptic Solution	Claritin
Bacitracin/Neomycin/Polymyxin	Sudafed
Calamine/Caladryl Lotion	Imodium
Hydrocortisone Cream	Mylanta
Ivarest Cream	Tums
Cepecol Lozenges	Pepto-Bismal
Chloraseptic	Milk of Magnesia
Robitussin	Sunscreen

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form RECOMMENDATIONS FOR LICENSED MEDICAL PERSONNEL (FORM 2). *Attach additional information if needed.*

Physical exam done today: □ Yes □ No (if "No", date of last physical: _____ month/day/year)

ACA Standards specify physical exam should be within the last 12 months of the last day of camp

Weight: _____ lbs. Height: _____ ft. _____ in. Blood Pressure: _____/_____

Allergies: □ No Known Allergies

□ To foods (list): _____

□ To medications (list): _____

□ To the environment (list): _____

□ Other allergies (list): _____

Describe previous reactions:

Diet/Nutrition: □ 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 Medication □ Will take the following prescribed medication(s) while at camp **(must list name, dose, time, frequency 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). All information included on the CAMPER HEALTH HISTORY FORM (FORM 1) and the RCOMMENDATIONS FOR LICENSED MEDICAL PERSONNEL (FORM 2) is accurate and has my professional endorsement."

Name of Licensed Provider (please print): _____ Signature: _____ Title: _____

Office Address: _____ (Street Address / City / State / Zip Code)

Telephone: (_____) _____ - _____ Date: _____