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

**To Parent(s)/Legal guardian(s): Complete this section and take this form (Form 2) with Form 1 to your child’s health-care provider for review. After completion, mail Form 1 and Form 2 to Highlands. Forms must be returned 10 days prior to the session start in order to attend camp.**

Camper Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First Middle Last

Camp Attending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Camp Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Male ❑ Female Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age on arrival at camp: \_\_\_\_\_\_\_

 (Month/Day/Year)

Camper home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip

Parent(s)/Legal Guardian(s) name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent(s)/Legal Guardian(s) phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_

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



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**Other treatments/therapies**: to be continued at camp(describe below): □ None needed

**Current Tx**: The camper is undergoing treatment at this time for the following conditions (describe below): □ None

**Diet, Nutrition:** □ Eats a regular diet. □ Has a medically prescribed meal plan or dietary restrictions (describe below):

**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 12 months.

Weight \_\_\_\_\_\_ lbs Height: \_\_\_\_\_ft \_\_\_\_\_in Blood Pressure \_\_\_\_\_\_/\_\_\_\_\_\_\_

The following non-prescription medications may be 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) Mucinex D

Bacitracin Mucinex DM

Benadryl Cream Naproxen (Aleve)

Benadryl Tabs Nasal Saline Spray

Chloraseptic Spray Pepcid (famotidine)

Claritin (loratidine) Sterile Saline

Cortaid Sucrets Lozenges

Epsom salts

Gatorade **Prescription Medications**

Ibuprofen Adrenalin (Epiephrine – Epi-Pen Jr.)

Milk of Magnesia Inhaler Albuterol

**Allergies: □** No known allergies. ***Describe previous reactions*:**

□ To foods (list):

□ To Medications (list):

□ To the environment (insect stings, hay fever, etc. - list):

□ Other allergies (list):

**Medication:** □ No daily medications □ Will take prescribed medication(s) while at camp

Please attach a list of **MEDICATIONS (including over-the-counter meds), DOSAGE, and FREQUENCY**

If you answered “Yes” to the question above, what do you recommend? (Describe below – attach additional information if needed.)

Do you feel that the camper will require limitations or restrictions to activity while at camp? □ No □ Yes

I have reviewed the Camper Health History Form (Form 1), and have discussed the camp program with the camper’s parent(s)/legal 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

Telephone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_