Christian Camps and Conferences

Legal Name: ______________________________ __________

First Middle Last "Nickname"

☐ Male ☐ Female Birth Date __________ Age on arrival at camp: ________

Month/Day/Year

# Medical Provider Form

Parents, please provide the form to your child's health care provider for review and completion
**After** the health care provider has completed and signed the form, **return it to the camp by May 1st.**
We suggest you keep a copy of the completed form for your records.

Weight: _______ lbs Height: _____ft_____in Blood Pressure_______/_______

**Physical exam done today:** ☐ **Yes** ☐ **No** **(If "No," date of last physical: ________________)**

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, 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 on this form.)**

Name of licensed provider (please print): ______________________Signature: __________________Title: ___________

Office Address________________________________________________________________________________

Street City State Zip Code

Telephone: ( ) Date:

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.

**Cross out those items the camper should not be given.**

**Acetaminophen** (Tylenol) **Aloe** **Ammonia inhalent** (for fainting) **Bacitracin ointment**
**Bactroban 2% ointment** (Mupirocin – for skin infection)
**Benzocaine gel** (Orasol, Anbesol – for toothaches)
**Calamine lotion** **Calcium Carbonate** (Tums – antacid) **Cetirizine** (Zyrtec – antihistamine)
**Dextromethorphan** (Robutussin DM, Delsym – cough syrup)
**Diphenhydramine** (Benadryl – antihistamine) **Epinepherine** (Epipen – for anaphylaxis)
**Generic cough drops** **Guaifenesin** (Robutussin – cough syrup) **Hydrocortisone 1% cream**
**Ibuprofen** (Advil, Motrin) **Lidocaine Gel** (pain relieving burn gel)
**Loperamide** (Immodium AD – antidiarrheal)
**Loratadine** (Claritin – antihistamine) **Milk of Magnesia** (laxative)
**Phenol spray** (Chloraseptic – Sore throat spray)
**Phenylephrine** (Sudafed PE – decongestant) **Pseudophedrine** (Sudafed – decongestant)
**Tolnaftate** 1% cream (antifungal)

**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)**

Name: ______________________________________________
First Middle Last

**Medication:** ☐ This camper will not take any daily medications while attending camp.
☐ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. The camp requires original pharmacy containers with labels which show the camper's name and how the medication should be given. Parents need to provide enough of each medication to last the entire time the camper will be at camp.

| Name of medication | Amount or dose given | How it is given | When it is given | Reason for taking it | Date started |
|---|---|---|---|---|---|
| | | | ☐Breakfast<br>☐Lunch<br>☐Dinner<br>☐Bedtime<br>☐Other time:_______ | | |
| | | | ☐Breakfast<br>☐Lunch<br>☐Dinner<br>☐Bedtime<br>☐Other time:_______ | | |
| | | | ☐Breakfast<br>☐Lunch<br>☐Dinner<br>☐Bedtime<br>☐Other time:_______ | | |
| | | | ☐Breakfast<br>☐Lunch<br>☐Dinner<br>☐Bedtime<br>☐Other time:_______ | | |

**Inhaler / Epi-Pen authorization: Camper has Inhaler Epi-Pen** (circle one) **with them and may self-administer.**
☐ Not Needed ☐ No ☐ Yes _______ (initials of health care provider)

**Immunization History:** Provide the month and year for each immunization. Starred (*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

| Immunization | | Dose 1 Month/Year | Dose 2 Month/Year | Dose 3 Month/Year | Dose 4 Month/Year | Dose 5 Month/Year | Most Recent Dose Month/Year |
|---|---|---|---|---|---|---|---|
| Diptheria, tetanus, pertussis* (DTaP) or (TdaP) | | | | | | | |
| Tetanus booster* (dT) or (TdaP) | | | | | | | |
| Mumps, measles, rubella* (MMR) | | | | | | | |
| Polio* (IPV) | | | | | | | |
| Haemophilus influenzae type B (HIB) | | | | | | | |
| Pneumococcal (PCV) | | | | | | | |
| Hepatitis B | | | | | | | |
| Hepatitis A | | | | | | | |
| Varicella (chicken pox) | ☐Had chicken pox Date: | | | | | | |
| Meningococcal meningitis (MCV4) | | | | | | | |