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 by ______ (date)

Some non-prescription medications are commonly stocked in the Camp Health Center. These are used on an as needed basis to manage illness and injury.

**Medical personnel: please list any items should not be given.**

<table>
<thead>
<tr>
<th>Diet, Nutrition</th>
<th>Eats a regular diet.</th>
<th>Has a medically prescribed meal plan or dietary restrictions: (describe below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The camper is undergoing treatment at this time for the following conditions: (describe below)</td>
<td>None.</td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td>No daily medications.</td>
<td>Will take the following prescribed medication(s) while at camp: (name, dose, frequency—describe below)</td>
</tr>
<tr>
<td>Other treatments/therapies to be continued at camp: (describe below)</td>
<td>None needed.</td>
<td></td>
</tr>
</tbody>
</table>

**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 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:

**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.)*

Name of licensed provider (please print): ____________________________

Signature: ____________________________

Title: ____________________________

Telephone: (________)_____________________

Office Address: ____________________________________________________________

City: ____________________________ State: ____________________________ Zip Code: ____________________________

Date: ____________________________

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