Health Care Recommendations by Licensed Medical Personnel

Camper Name_____

I examined this individual on _____. (ACA-accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.)

BP _____ Weight _____ Height _____

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions

_____

_____

_____

_____

Recommendations and Restrictions at Camp

Treatment to be continued at camp _____

_____

Medications to be administered at camp (name, dosage, frequency)_____

_____

Any medically-prescribed meal plan or dietary restrictions _____

_____

Known allergies_____

_____

Description of any limitation or restriction on camp activities_____

_____

Additional information for health care staff at the camp_____

_____

Signature of Licensed Medical Personnel _____

Printed_____Title_____

Address _____

Phone _____Date_____

For camp use only

Screening Record

Date screened_____Time_____ am pm

Meds received _____

_____

Updates/additions to health history noted ☐ Yes ☐ No ☐ None required

Current health needs identified _____

_____

Observational notes_____

_____

Screened by _____