

eliminating racism empowering women ywca

Northern New Jersey

Bergen • Essex • Hudson • Morris • Passaic

To Parent(s)/Guardian(s): Complete this section 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 _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last

Male Female Birth Date _____ Age on arrival at camp _____
Month/Day/Year

Camper home 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.

Camper Name
First

Middle

Last

(For Camp Use) Cabin or Group

(For Camp Use) Session Code(s):

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

- | | |
|----------------------------------|--------------------------------------|
| Acetaminophen (Tylenol) | Calamine lotion |
| Ibuprofen (Advil, Motrin) | Bismuth subsalicylate (Pepto-Bismol) |
| Diphenhydramine (Benadryl) | Hydrocortisone 1% cream |
| Generic cough drops | Topical antibiotic cream |
| Chloraseptic (Sore throat spray) | Calamine lotion |
| | Aloe |

Medical Personnel: Please complete this form

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:

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) None.

Medication: No daily medications. Will take the following prescribed medication(s) while at camp: (*name, dose, frequency - describe 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.)

Name of licensed provider (please print): _____ Signature: _____ Title: _____

Office Address _____
Street City State Zip Code

Telephone: (____) _____ Date: _____