



**PLEASE RETURN TO:**  
**WINTER** (September 1 - May 1)  
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 p: 800-494-6238 f: 561-883-6490

**SUMMER** (May 1 - August 31)  
 700 Churchill Street, Pittsfield, MA 01201  
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# CAMPER MEDICAL FORM

**TO BE COMPLETED BY PHYSICIAN**

Camper Name (First, Middle, Last) \_\_\_\_\_

Birth Date \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent / Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_

<p>The following non-prescription medications are commonly stocked in camp Health Centers and are used on an <b>as needed basis</b> to manage illness and injury. <b>Medical personnel: Cross out those items the camper should not be given.</b></p> <ul style="list-style-type: none"> <li>Acetaminophen (Tylenol)</li> <li>Ibuprofen (Advil, Motrin)</li> <li>Phenylephrine (Sudafed PE)</li> <li>Pseudoephedrine (Sudafed)</li> <li>Chlorpheniramine maleate</li> <li>Guaifenesin</li> <li>Dextromethorphan</li> <li>Diphenhydramine (Benadryl)</li> <li>Generic cough drops</li> <li>Chloraseptic (Sore throat spray)</li> <li>Lice shampoo or scabies cream (Nix or Elimite)</li> <li>Calamine lotion</li> <li>Bismuth subsalicylate (Pepto-Bismol)</li> <li>Laxatives for constipation (Ex-Lax)</li> <li>Hydrocortisone 1% cream</li> <li>Topical antibiotic cream</li> <li>Calamine lotion</li> <li>Aloe</li> </ul>	<p><b>Medical Personnel:</b> Please review the Camper Health History Form and complete all remaining sections of this form. Attach additional information if needed.</p> <hr/> <p><b>Physical exam done today:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," date of last physical: _____)  <small>Month/Day/Year</small></p> <p><b>ACA accreditation standards specify physical exam within last 24 months.</b></p> <p>Weight: _____ lbs Height: _____ ft _____ in Blood Pressure _____ / _____</p> <p><b>Allergies:</b> <input type="checkbox"/> No Known Allergies</p> <p><input type="checkbox"/> To foods (<b>list</b>):</p> <p><input type="checkbox"/> To medications: (<b>list</b>):</p> <p><input type="checkbox"/> To the environment (<b>insect stings, hay fever, etc. – list</b>):</p> <p><input type="checkbox"/> Other allergies: (<b>list</b>):</p> <p><b>Describe previous reactions:</b></p>
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**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 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: \_\_\_\_\_

# CAMPER MEDICAL FORM page 2

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Camper Name: \_\_\_\_\_  
First Middle Last  
 Birth Date: \_\_\_\_\_  
Month/Day/Year

**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
Diphtheria, 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)	<input type="checkbox"/> Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test      Date: \_\_\_\_\_       Negative       Positive

**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. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

- |   |   |
|---|---|
| Acetaminophen (Tylenol)                                   | Ibuprofen (Advil, Motrin)                                     |
| Phenylephrine decongestant (Sudafed PE)                   | Pseudoephedrine decongestant (Sudafed)                        |
| Antihistamine/allergy medicine                            | Guaifenesin cough syrup (Robitussin)                          |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Dextromethorphan cough syrup (Robitussin DM)                  |
| Sore throat spray   | Generic cough drops   |
| Lice shampoo or cream (Nix or Elimite)                    | Antibiotic cream  |
| Calamine lotion   | Aloe  |
| Laxatives for constipation (Ex-Lax)                       | Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |