(For Camp Use) Session Code(s): _____

(For Camp Use) Cabin or Group _____

Camper Name _____ First _____ Middle _____ Last

CAMPER HEALTH-CARE RECOMMENDATIONS
by LICENSED MEDICAL PERSONNEL FORM 2

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

Return this form to camp prior to June 1st

Black River Farm and Ranch
5040 Sheridan Line
Croswell, MI 48422

forms@blackriverfarmandranch.com
Upload a PDF in the registration portal

Parent(s) / Guardian(s): Complete this section only and give to your health care provider *to complete the camper physical. Be sure to review any concerns you may have noted in the health history form with your provider.*

Dates will attend camp: from _____ (Month/Day/Year) to _____ (Month/Day/Year)

Camper Name: _____ (First) _____ (Middle) _____ (Last)

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

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.

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM and complete all remaining sections of this form. Attach additional information if needed.

Physical exam done today: ☐ Yes ☐ No (**If "No," date of last physical**: _____ Month/Day/Year)

Black River Farm & Ranch specifys physical exam within last 12 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, 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: _____

Rev. 2/07 LEE/EAW