

Health Care Recommendations -To be completed by Licensed Medical Provider

You may substitute your physician's generic form for this page as long as the information provided is comparable.

Camper Name _____ *** I EXAMINED THIS INDIVIDUAL ON _____ (Date)**
(ACA accreditation and State of NH requirements specify exams within 24 months of camp attendance.)

*DOB _____ * Weight _____ * Height _____ *BP _____

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

The camper is current on all immunizations. ☐ Yes ☐ No **Please include a current immunization record**

The camper 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)

Med: _____ Dosage: _____ Frequency: _____

Med: _____ Dosage: _____ Frequency: _____

Med: _____ Dosage: _____ Frequency: _____

Med: _____ 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 Provider – **Updated signature required each year**

*Signature _____

*Print Name _____

*Title _____ *Date _____

*Address _____

*Phone (_____) _____ *Fax (_____) _____