

# YMCA Camp Weaver Health-Care Recommendations

## By Licensed Medical Personnel

Mail this form to YMCA Camp Weaver 2 weeks prior to session. YMCA Camp Weaver, 4924 Tapawingo Trail, Greensboro, NC 27406

**To Parent(s)/Guardian(s):** Complete this section and give this form and a copy of your complete CAMPER HEALTH HISTORY FORM to your child's health-care provider for review.

Session attending: \_\_\_\_\_

Camper Name: \_\_\_\_\_

Male  Female    Birth Date \_\_\_\_\_ Age on arrival \_\_\_\_\_  
First Middle Last  
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.**

The following non-prescription medications are commonly stocked in the camp infirmary 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)
- Ibuprofen (Advil, Motrin)
- Phenylephrine (Sudafed PE)
- Pseudoephedrine (Sudafed)
- Chlorpheniramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chlorasptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimite)
- Calamine Lotion
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Aloe

**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

**American Camp Association Accreditation standards specify a 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 strings, 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

Telephone: (\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_\_