

YMCA Camp Weaver Health-Care Recommendations By Licensed Medical Personnel

Mail this form to YMCA Camp Weaver 1 week 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: _____
First Middle Last

Male Female Birth Date _____ Age on arrival ____
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 camp 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: _____
Please keep in mind that some doctors charge a fee for completing this form, if done without a regular appointment.

For office use only. → Camper's name _____ Session _____ Cabin Name _____