Corps or Service Center: _____ Cabin _____

Camp sessions attending: _____

Physician's Health-Care Recommendation & Examination Form
The Salvation Army Residential Camp

This form is to be filled out by a licensed medical doctor or nurse practitioner.

Camper/Staff name _____ □ Male □ Female D.O.B. _____/_____/_____ Age _____
First Middle Last

Note to medical personnel: Please reviews the CAMPER/STAFF INFORMATION & HEALTH HISTORY FORM filled out by the parent/guardian, and complete all remaining sections of this form. Attach additional information if needed.

PHYSICAL EXAM:

Is the physical exam done today? □ YES □ NO (If "NO," date of the last physical exam: _____)

NOTE: Physical exam must take place within 24 months of attending camp.

Blood pressure _____ Weight _____lbs Height _____ ft _____in

Allergies: □ No known allergies □ Camper has allergies to the following (please list allergens & describe reaction & treatment)

Food: _____

Medications: _____

Environmental: (insects, plants, hay fever, etc):_____

Other Allergies: _____

Does the camper require an Epi-pen for treatment of allergies? □ Yes □ No (If yes, the child must have an Epi-pen prescribed in his/her name, which must accompany the child to camp)

Medications stocked in our camp's Health Center and will be used to manage illness and/or injury of this employee.
CROSS OUT those below that are contraindicated for this person.

Aloe	Calamine Lotion	Hydrogen peroxide	Topical Antibiotic Cream
Antacid tablets	Dextromethorphan	Ibuprofen	Phenylephrine decongestant
Anticeptic wash (Bactine or Johnson & Johnson Band-Aid wash)	Diphenhydramine (Benadryl)	Lidocaine	Sore throat spray/lozenge
	Docusate sodium (stool softener)	Lopermide (Immodium)	Silver Sulfadiazine (burn cream)
		Cough Drops	
Bismuth subsalicylate (Pepto-Bismol)	Guiafenesin	Nix/Rid	Ivy-Dry Product
	Hydrocortisone Cream	Tolnaftate	Acetaminophen (Tylenol)

DIET & NUTRITION: □ Eats a regular diet □ Has a medically prescribed meal plan or dietary restrictions as described below:

_____

_____

CURRENT MEDICAL TREATMENT: □ No current medical treatment □ Camper is under the treatment for condition described below:

_____

_____

TREATMENT TO BE CONTINUED AT CAMP:

_____

_____

PHYSICAL LIMITATIONS: □ No physical limitations □ Camper may have the following physical limitations/restrictions while at camp:

_____

_____

CURRENT MEDICATIONS: Pease list prescription meds, as well as OTC meds/creams that will need to be administered at camp. Also, if Epi-pen is to be brought to camp, it must be indicated here. Please indicate if a medicine is only "as needed."

Name of Medication	Dosage	Frequency	Reason

Additional information for camp health care staff:

_____

_____

I have reviewed the Camper/Staff Information & Health History Form completed by the child's parent, and I have discussed the camp program with the camper/staff's parent/guardian. It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Signature of physician: _____ Date: _____

Printed name: _____ Title: _____ Phone: _____

Name of medical group/practice: _____

Address of practice: _____