Please Return by May 1st
Camp Horseshoe
PO Box 1938
Highland Park, IL 60035

# CAMPER HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL

**Camper Name:** _____ **DOB:**_____

**Physical Exam done today:** ☐ **Yes** ☐**No** (If "No," date of last physical:_____)

Weight:_____lbs Height: _____ft_____inches 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:***

The following non-prescription medications are commonly stocked in camp Health Centers and 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)
Chlorpheneramine maleate
Guaifenesin
Dextromethorphan
Diphenhydramine (Benadryl)
Generic cough drops
Chloraseptic (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
Calamine lotion
Aloe

## 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 examined the person herein described and have reviewed the health history. 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): _____ Title: _____ Date: _____

Office Address: _____
Street City State Zip

Signature: _____