



Please Return by April 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)
- Chlorpheniramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimate)
- 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: _____