CAMPER HEALTHCARE RECOMMENDATIONS by LICENSED MEDICAL PERSONNEL

This form should be returned ONE MONTH prior to arrival at camp.

To return by mail:
Camp Dixie
373 Bladen Union Church Rd
Fayetteville, NC 28306

To return by fax:
(910) 865-4277

To Parent(s)/Guardian(s) Complete this section *and give this form to your child's health-care provider to complete.*

Camp Session (circle one): □ KC#1 □ KC#2 (early session) □ KC #2 □ TC #1 □ TC #2

Camper Name: _____

□ Male □ Female Date of Birth _____ (Month/Day/Year) Age on arrival at camp _____

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.

Camper Name First Middle Last

(For Camp Use) Cabin

(For Camp Use) Session Code(s):

The following non-prescription medications will be stocked in Camp Dixie's nurse's station and may be 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)
Aloe
Calamine lotion
Bismuth subsalicylate (Pepto-Bismol)
Laxatives for constipation (Ex-Lax)
Hydrocortisone 1% cream
Topical antibiotic cream

Medical Personnel: Please 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)

Camp Dixie requires that a physical exam be given within 24 months of arrival at camp.

Month/Year of last Tetanus Immunization: _____

Is child current on immunizations required by the NC Dept. of Health and Human Services for school? □ Yes □ No

Weight: _____lbs. **Height:** _____ft_____in **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:

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 discussed the camp program with the camper's parent(s)/guardian(s), and 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 _____
Address City State Zip Code

Telephone: (_____)_____ Date: _____