# CAMPER HEALTHCARE RECOMMENDATIONS by LICENSED MEDICAL PERSONNEL

***This form should be returned TWO WEEKS prior to arrival at camp.***

***To return by mail:***
***Camp Dixie***
***373 W 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 ______________ Age on arrival at camp ________
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.***

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.**

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______________________________________________
Street City State Zip Code

Telephone: (________)____________________ Date:____________________