

Deerfoot Lodge Health Care Recommendations by Licensed Provider
 This form is to be completed and signed by a Licensed Medical Provider within two years of the camper session.

Camper Name: _____ **Date of Physical:** _____

D.O.B: _____ **Height:** _____ **Weight:** _____ **Blood Pressure:** _____

MEDICAL HISTORY

- | | | |
|--|---|---|
| <input type="checkbox"/> No Health Concerns | <input type="checkbox"/> Bone/Muscle Injury | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Head Injury/Concussion |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Diabetes (MD signature required on Diabetic Care Plan) |
| <input type="checkbox"/> Attention Deficit Diagnosis (ADHD, ADD) | <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Other: |

In my opinion, the above condition does does not (check one) limit the camper's participation in a very active wilderness camp.

Current Treatment:

Activities to be encouraged or limited:

MEDICATIONS New York State requires all Prescription AND over-the-counter medications that are taken regularly by a camper to be listed on this form

Diagnosis	Medication	Dosage	Frequency

The following non-prescription medications are stocked in the camp Health Center and are used on an as needed basis to manage illness or injury. Please check those items the camper SHOULD NOT be given:

ANALGESICS	No	COUGH MEDICATION	No	GASTRO-INTESTINAL	No
Tylenol	<input type="checkbox"/>	Delsym	<input type="checkbox"/>	Tums	<input type="checkbox"/>
Ibuprofen	<input type="checkbox"/>	Robitussin DM	<input type="checkbox"/>	Zantac	<input type="checkbox"/>
Naproxen	<input type="checkbox"/>	DECONGESTANT	No	OTIC	No
Cepacol Throat Lozenges	<input type="checkbox"/>	Allergy/Sinus Caplets	<input type="checkbox"/>	Swim Ear Drops	<input type="checkbox"/>
Chloraseptic Throat Spray	<input type="checkbox"/>	Day-time Cold Caplets	<input type="checkbox"/>	TOPICAL	No
ANTIHISTAMINE	No	Dimetapp	<input type="checkbox"/>	Bacitracin Ointment	<input type="checkbox"/>
Benadryl	<input type="checkbox"/>	Night-time Cold Capsules	<input type="checkbox"/>	Benadryl Spray	<input type="checkbox"/>
Claritin	<input type="checkbox"/>	GASTRO-INTESTINAL	No	Biofreeze	<input type="checkbox"/>
Zyrtec	<input type="checkbox"/>	Dramamine	<input type="checkbox"/>	Calamine Lotion	<input type="checkbox"/>
COUGH MEDICATION	No	Imodium	<input type="checkbox"/>	Hydrocortisone Cream	<input type="checkbox"/>
Mucinex	<input type="checkbox"/>	Maalox	<input type="checkbox"/>	Sunscreen	<input type="checkbox"/>

IMMUNIZATIONS

Attach a copy of immunizations

*A Legal Waiver must be signed for conscientious exemption (Exemption form available upon request)

ALLERGIES

- No known allergies
- Food (MD signature required on dietary form, available upon request)
- Medication/s: Insect Stings:
- Other Anaphylaxis? Yes No Describe reaction(s) & management:

Licensed Medical Provider Signature: _____ Date: _____

Physician Name (print): _____

Address: _____

Name:

Session:

Section:

Year: