Form B: Camper Health Care Recommendations
To Be Completed By Licensed Medical Personnel

Camper's Name: _____
(First) (Middle) (Last)

Home Address: _____
(Street Address) (City) (State) (Zip Code)

Gender: ○ M ○ F Date Of Birth: _____/_____/_____ Age On Arrival At Camp: _____

Session(s) Attending Camp In 2015:
If attending for multiple sessions, check all that apply

- ☐ CIT (June 19 - August 9)
- ☐ Session 1: LONG (June 21 - July 17)
- ☐ Session 2: LONG (July 20 - August 9)
- ☐ Session 1S: SHORT (June 21 - July 3)
- ☐ Session 2S: SHORT (July 5 - July 17)
- ☐ Rookie 1 (July 20 to July 26)
- ☐ Rookie 2 (July 27 - August 2)

Custodial Parent(s)/Guardian(s) Preferred Phone Numbers Home (_____) _____-_____ Cell (_____) _____-_____

STOP Parent(s)/Guardian(s) Stop Here. The Rest Of The Form Is To Be Completed By Medical Personnel STOP

According to the American Camper Association Guidelines, campers must have a physical examination within one year to his/her arrival to camp.

Was a physical exam done today? ○ Yes ○ No (If "No", what was the date of the last physical exam? ___/___/___)

Weight: _____ lbs Height: _____ ft _____in Blood Pressure: _____/_____

ALLERGIES

○ No Known Allergies This Camper Is Allergic To: ○ Foods ○ Medications ○ Environment (Insect Stings, Hay Fever, Etc.) ○ Other

List And Describe Previous Reactions:

DIET AND NUTRITION:

○ Eats a regular diet ○ Has a medically prescribed meal plan or dietary restrictions. Describe below:

TREATMENTS:

The camper is undergoing treatment at this time for the following conditions:
○ None ○ Describe Below

Other treatments/therapies to be continued at camp:
○ None ○ Describe Below

Do you recommend that the camper follow any limitations or restrictions to activity while at camp? ○ Yes ○ No
If "Yes", what do you recommend? Please attach additional information if needed.

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MEDICATION

All medication must be ordered from Finksburg Pharmacy.
All medicine including vitamins, natural remedies, and over-the-counter medication requires a doctor's order. Any medications listed on FORM B should match FORM C.

	Medication	Strength	Qty Dispensed	Directions and Time (circle a time)	Notes
1)				9am | 1pm | 6pm | 9pm | PRN	
2)				9am | 1pm | 6pm | 9pm | PRN	
3)				9am | 1pm | 6pm | 9pm | PRN	
4)				9am | 1pm | 6pm | 9pm | PRN	
5)				9am | 1pm | 6pm | 9pm | PRN	

IMMUNIZATION HISTORY

Provide the month and year for each immunization. Starred (*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, Tetanus, Pertussis (DTaP or TdaP) *						
Tetanus Booster (dT or TdaP) *						
Mumps, Measles, Rubella (MMR) *						
Polio (IPV) *						
Haeophilus Influenzae Type B (HIB)						
Hepatitis B						
Hepatitis A						
Varicella (Chicken Pox) ✓ Had Chicken Pox Date: _____						
Meningococcal meningitis (MCV4)						

"I have reviewed FORM A: CAMPER HEALTH HISTORY FORM, and have discussed the camp program with the camper's parent(s)/ guardian(s). 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 Address) (City) (State) (Zip Code)

Phone Number (_____) _____-_____ Date _____/_____/_____