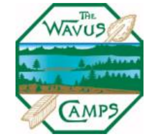

Kieve-Wavus Education, Inc.
PO Box 169, Nobleboro, ME 04555

CAMPER HEALTHCARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL FORM 2

Please Print All Information

Return Completed Form to

Kieve-Wavus Education, Inc.
PO Box 169
Nobleboro, ME 04555

Questions?
Call Faye at Camp Kieve
(207-563-5172)
or
Call Deb at Wavus Camp
(207-549-5719)

To Parents(s)/Guardian(s): Complete this section and give **this form (FORM 2) and** a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1) to your child's health-care provider for review.

Dates will attend camp: _____/_____/_____ to _____/_____/_____
Month Day Year Month Day Year

Camper Name: ____
First Name Middle Last

☐ M ☐ F Birth Date: _____/_____/_____ Age on arrival at camp __________
Month Day Year

Camper Home Address:

____
Street Address City State Zip Code

Custodial parent(s)/guardian(s) telephone: (_____) __________________________

PARENT(S)/GUARDIAN(S) STOP HERE. REST OF FORM TO BE COMPLETED BY MEDICAL PERSONNEL.

The following non-prescription medications are commonly stocked in our camp's Health Center and will be used on an as needed basis to manage illness and/or injury.
Medical personnel:
CROSS OUT those items the camper should not be given...

Acetaminophen (Tylenol)
Aloe
Antibiotic cream, topical
Antihistamine/allergy medicine
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)
Calamine lotion
Chlorpheniramine maleate
Dextromethorphan cough syrup (Robitussin DM)
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Epinephrine
Generic cough drops
Guaifenesin cough syrup (Robitussin)
Hydrocortisone Cream
Ibuprophen (Advil, Motrin)
Ivy Dry
Laxatives for constipation (Ex-Lax)
Lice shampoo or cream (Nix or Elimite)
Phenylephrine decongestant (Sudafed PE)
Pseudoephedrine decongestant (Sudafed)
Silver Sulfadiazine
Sore throat spray
Tolnaftate

Physical exam done today: ☐ Yes ☐ No (If no, date of last physical _____/_____/_____)
Month Day Year

ACA accreditation standards specify physical exam within last 24 months.

Weight ______ lbs Height _______ft ______ in Blood Pressure ________/________

Allergies: ☐ No known allergies
☐ Food *(list)* ☐ Medicine *(list)* ☐ The environment (insect stings, hay fever, etc.) *(list)*

☐ Other *(list)*

Describe previous reactions:

Diet, Nutrition: ☐ This camper eats a regular diet ☐ Has a medically prescribed meal plan or dietary restrictions: (**describe below**)

This camper is undergoing treatment at this time for the following conditions: (describe below). ☐ None

Medication: ☐ No daily medications ☐ Will take the following prescribed daily medication(s) while at camp. **(name, dose, frequency – describe below)**

☐ This camper may carry & self-administer medication(s) – Please complete the *Approval for Self-Administered Medication Form (both sides)*

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 reviewed the CAMPER HEALTH HISTORY FORMS (FORM 1), 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

Telephone (_____) ______________________ Date _____/_____/_______

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