



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



CAMPER HEALTHCARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL FORM 2

Please Print All Information

<p style="color: red; text-align: center;"><i>Return Completed Form to</i></p> <p>Kieve-Wavus Education, Inc. PO Box 169 Nobleboro, ME 04555</p> <p>Questions? Call Faye at Camp Kieve (207-563-5172) or Call Deb at Wavus Camp (207-549-5719)</p>	<p><u>To Parents(s)/Guardian(s):</u> 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.</p> <p>Dates will attend camp: ____/____/____ to ____/____/____ Month Day Year Month Day Year</p> <p>Camper Name: _____ First Name Middle Last</p> <p><input type="checkbox"/> M <input type="checkbox"/> F Birth Date: ____/____/____ Age on arrival at camp _____ Month Day Year</p> <p>Camper Home Address: _____ Street Address City State Zip Code</p> <p>Custodial parent(s)/guardian(s) telephone: (____) _____</p> <p style="color: red; text-align: center;">PARENT(S)/GUARDIAN(S) STOP HERE. REST OF FORM TO BE COMPLETED BY MEDICAL PERSONNEL.</p>
<p>The following non-prescription medications are commonly stocked in our camp's Health Center and will be used on an <u>as needed</u> basis to manage illness and/or injury.</p> <p>Medical personnel: CROSS OUT those items the camper should <u>not</u> be given...</p> <p>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</p>	<p>Physical exam done today: <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, date of last physical ____/____/____) Month Day Year</p> <p style="color: red;">ACA accreditation standards specify physical exam within last 24 months.</p> <p>Weight ____ lbs Height ____ ft ____ in Blood Pressure ____/____</p> <p>Allergies: <input type="checkbox"/> No known allergies <input type="checkbox"/> Food (<i>list</i>) <input type="checkbox"/> Medicine (<i>list</i>) <input type="checkbox"/> The environment (insect stings, hay fever, etc.) (<i>list</i>)</p> <p><input type="checkbox"/> Other (<i>list</i>)</p> <p>Describe previous reactions:</p> <p>Diet, Nutrition: <input type="checkbox"/> This camper eats a regular diet <input type="checkbox"/> Has a medically prescribed meal plan or dietary restrictions: (describe below)</p> <p>This camper is undergoing treatment at this time for the following conditions: (describe below). <input type="checkbox"/> None</p> <p>Medication: <input type="checkbox"/> No daily medications <input type="checkbox"/> Will take the following prescribed daily medication(s) while at camp. (name, dose, frequency - describe below)</p> <p><input type="checkbox"/> This camper may carry & self-administer medication(s) - Please complete the <i>Approval for Self-Administered Medication Form (both sides)</i></p> <p>Other treatments/therapies to be continued at camp: (describe below) <input type="checkbox"/> None needed</p>
<p>Do you feel that the camper will require limitations or restrictions to activity while at camp? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If you answered "Yes" to the question above, what do you recommend? (describe below - attach additional information if needed)</p>	
<p>"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).</p>	
<p>Name of licensed provider (please print): _____ Signature _____ Title _____</p> <p>Office Address _____ Street Address City State Zip Code</p> <p>Telephone (____) _____ Date ____/____/____</p>	
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