FORM 2 complete	t(s)/Guardian(s): Complete this section and give this form (FORM 2) and a copy of your d CAMPER HEALTH HISTORY FORM (FORM 1) to your child's health-care provider for review. attend camp: fromto
American Academy of Penaltics Council on School Health, a Camper N american Academy Nurses Camper N american Academy School Health, a Camper N Mail this form to the address below by May 1 st	ame:
Blue Mountain Ranch P.O. Box 146 Florissant, CO 80816	State Zip Code parent(s)/guardian(s) phone: () () guardian(s) stop here. Rest of form to be completed by medical personnel. ()
CONVENIENT PHYSICALS AVAILABLE AT: The altheare clinic at select Walgreens	Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Middle Attach additional information if needed. Middle
Proud Partner of American Camp Association	Physical exam done today: Yes No (If "No," date of last physical:)
The following non-prescription medications are commonly stocked in carr	ACA accreditation standards specify physical exam within the last 12 months.
Health Centers and are used on an <u>as needed basis</u> to manage illness and injury. <u>Medical personnel:</u> Cross out those items the camper should	
not be given.Acetaminophen (Tylenol)Lice shampoo or scabies creamIbuprofen (Advil, Motrin)(Nix or Elimite)Phenylephrine (Sudafed PE)Calamine lotionPseudoephedrine (Sudafed)Bismuth subsalicylate (Pepto-BismonChlorpheneramine maleateLaxatives for constipation (Ex-Lax)GuaifenesinHydrocortisone 1% creamDextromethorphanTopical antibiotic creamDiphenhydramine (Benadryl)Calamine lotionGeneric cough dropsAloe	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)	
Do you feel that the camper will require limitations or restrictions to activity while at camp? 🗆 No 🗆 Yes	
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) If you answered "Yes" to the question above, what do you recommend? (describe below – attach additional information if needed) If you answered "Yes" to the question above, what do you recommend? (describe below – attach additional information if needed) If you answered "Yes" to the question above, what do you recommend? (describe below – attach additional information if needed) If you answered "Yes" to the question above, what do you recommend? (describe below – attach additional information if needed) If you answered "Yes" to the question above, what do you recommend? (describe below – attach additional information if needed) If you answered "Yes" to the question above, what do you recommend? (describe below – attach additional information if needed) If you answered "Yes" to the question above, what do you recommend? (describe below – attach additional information if needed) If you answered "Yes" to the question above, what do you recommend? (describe below – attach additional information if needed) If you answered "Yes" to the question above, what do you recommend? (describe below – attach additional information if needed) If you answered "Yes" to the question above, what do you recommend? (describe below – attach additional information if needed) If you answered "Yes" to the question above, what do you recommend? Yes "I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program (except as noted above.) Name of licensed provider (pl	
"I have reviewed the CAMPER HEALTH HISTORY FORM (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 AddressStreet	City State Zip Code
Telephone: () Date:	
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