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

❒No Health Concerns
❒Anxiety
❒Asthma
❒Attention Deficit Diagnosis (ADHD, ADD)
❒Bone/Muscle Injury
❒Depression
❒Seizure Disorder
❒Sleep Problems
❒Headaches/Migraines
❒Head Injury/Concussion
❒Diabetes (MD signature required on Diabetic Care Plan)
❒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		Delsym		Tums	
Ibuprofen		Robitussin DM		Zantac	
Naproxen		DECONGESTANT	No	OTIC	No
Cepacol Throat Lozenges		Allergy/Sinus Caplets		Swim Ear Drops	
Chloraseptic Throat Spray		Day-time Cold Caplets		TOPICAL	No
ANTIHISTAMINE	No	Dimetapp		Bacitracin Ointment	
Benadryl		Night-time Cold Capsules		Benadryl Spray	
Claritin		GASTRO-INTESTINAL	No	Biofreeze	
Zyrtec		Dramamine		Calamine Lotion	
COUGH MEDICATION	No	Imodium		Hydrocortisone Cream	
Mucinex		Maalox		Sunscreen	
		Milk of Magnesia		Bugspray	

IMMUNIZATIONS	ALLERGIES
Attach a copy of immunizations	❒No known allergies
*A Legal Waiver must be signed for conscientious exemption (Exemption form available upon request)	❒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: