KNC Travel Camper Health Recommendations

To be filled out by Medical Personnel

This form must be received by the camp before your child arrives on-site. Each child attending camp must have their own form.

Mail this completed form to:

Camp Registration
Kalamazoo Nature Center
7000 N. Westnedge Ave.
Kalamazoo, MI 49009-6309

To Parent/Guardian: Complete this section and give this form and a copy of your completed Camper Health History (from registration) to your child's health-care provider for review.

Camper Name: ____
First Middle Last

Gender: Female/Male Birth Date: ______________ Age on arrival at camp:___________

Camper Home Address:____
Street Address

____
City State Zip Code

Custodial parent(s)/guardian(s) phone: (_____)_________________(_____)_________________

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

Medical Personnel: Please review the Camper Health History Form and complete all remaining sections of this form. Attach additional information if needed.

Physical Exam done today: □ Yes □ No (If "No," date of last physical: ________________)

Weight: ___________lbs Height: _____ft _____in
Blood Pressure ________/_________

Allergies: □ No known allergies.
□ To foods **(list):**
□ To medications **(list):**
□ To the environment **(insect stings, hay fever, etc. - list):**
□ Other **(list):**
Describe previous reactions:

The following non-prescription medications may be stocked in the camp Health Center and are used on an as-needed basis to manage illness and injury. **Medical personnel: cross out those the camper should not be given.**
Acetaminophen (Tylenol)
Bismuth subsalicylate (Pepto Bismol, Kaopectate)
Diphenhydramine (Benadryl)
Ibuprofen (Advil, Motrin)
Aloe
Calamine lotion
Sunscreen

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) □ None needed

Do you feel that the camper will require limitations or restrictions to activity while at camp? □ Yes □ No
If you answered "Yes" , what do you recommend? **(describe below-attach additional information if needed)**

"I have reviewed the Camper Health History Form and have discussed the camp program with the camper's parent/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:________________