Part Two – Health Care Recommendations by Licensed Medical Personnel

Note– Must be filled out by a physician (please answer all questions)

First Name:_____ Last Name:_____

Date:_____ Weight:_____ Height:_____ Blood Pressure: _____

In my opinion, the above applicant is / is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

_____

Treatments to be continued at camp: _____

_____

Limitations in camp activities:_____

_____

The NYS Dept. of Health was instructed in 2003 that all summer campers must have individual written orders from a physician before a camper can receive any medications, including Over The Counter (OTC) drugs. Medications will be distributed by our medical director. Please circle and initialize what medications you allow the camper to take.

Acetaminophen / Antibiotic Cream/ Aspirin/ Benadryl/ Calamine Lotion/ Claritin/ Cough Drops/ Ibuprofen/ Imodium/ Pepto Bismol/ Robitussin DM/ Sore Throat Spray/ Tums/ Tylenol

Other OTC Medications:_____

Physician's Signature and Date: _____

Phone #: (_____) _____

Physician Name:_____

Email: _____

Office Address:

_____

_____