Cornell University Cooperative Extension of Suffolk County

PECONIC DUNES 4-H CAMP
CAMPER HEALTH FORM

This document MUST completed and signed by a licensed health care provider.

Camper Name_____Date of birth_____/_____/_____

Parent/Guardian Name_____Relationship_____

Height_____ Weight_____ Blood pressure__/_____

Date of last physical exam (must be within 12 months of your camp stay) ____/_____/_____

The following non-prescription medications are stocked in the Camp Health Center and are used on an as needed basis to manage illness and injury. Medical personnel: Cross out the medications a camper **CANNOT** take. Dosage will be per label instructions by age/weight.

For fever/pain	For cold/allergies	For stomach	For topical treatment
Acetaminophen (Tylenol) Ibuprofen (Advil)	Diphenhydramine (Benadryl) Pseudoephedrine (Sudafed) Loratadine (Claritin)	Calcium antacid (Tums) Loperamide (Immodium)	Antibiotic ointment Burn ointment Aloe Calagel (anti-itch) Tecnu (poison ivy wash) Hydrocortisone cream Anti-sting/itch spray Chloraseptic spray Cough drops Swim Ear (ear drops) Antifungal spray/powder

This camper will take the following medication(s) while at camp (please include EPI Pens & Rescue Inhalers if applicable). Our medical staff cannot administer any medications (including over the counter medications) without the appropriate signature from the licensed Health Care Professional on this form.

Name of medication	Dosage	Schedule	Specific instructions (take with food, etc.)

ALLERGIES

Please explain specific allergen and reaction below:

Is the camper being treated for any medical condition(s) at this time?

❑ No ❑ Yes If yes, please describe the condition and treatment.

Do you feel that the camper will require limitations or restrictions on activities while at camp?

❑ No ❑ Yes If yes, please describe the limitations or restrictions.

I have reviewed this Camper Health Form and verify the information contained herein. It is my opinion that the camper is physically and emotionally fit to participate in an active camp program.

Healthcare provider signature_____Date_____

Phone_____ Address_____