Recommendations for Licensed Medical Personnel **FORM 2**

The Chosen Ministry
Respect Patience Compassion Joyfulness

MAIL FORM TO: THE CHOSEN MINISTRY
3107 TAIT TERRACE
NORFOLK, VA 23509
DEADLINE to Register: MAY 1, 2018

To Parent(s)/Guardian(s): Complete this section and give this form (FORM 2) and a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1) to your camper's health-care provider for review.

Camper will attend camp: from August 18th 2018 to Aug 20th 2018

Camper Name: _____
First Middle Last

☐Male ☐Female Birth Date _____ Age: _____
Month/Day/Year

Camper home address: _____
Street Address

_____
City State Zip Code

Parent/Guardian phone: (_____)_____ (_____)_____

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

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and Injury. **Medical personnel:** Cross out those items the camper should *NOT* be given.

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin
- Phenylephrine (Sudafed PE)
- Pseudoephedrine (Sudafed)
- Chlorpheneramine maleate
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimite)
- Bismuth subsalicylate (Pepto-Bismol
- Topical antibiotic cream
- Calamine lotion
- Bug Spray
- Sun Screen
- Calamine lotion
- Guaifenesin
- Aloe

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

Physical exam done today: ☐ Yes ☐ No
(If "No," date of last physical: _____)
Month/Day/Year

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 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) ☐ None needed.

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? Does this camper need golf cart assistance to and from activities? (describe below: Attach additional information if needed)

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent/guardian. 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 City State Zip Code

Telephone:(_____)_____ **Date:**_____

Camper name: _____

(For Camp Use) Team: _____

Dates of Camp: Aug 18th to 20th 2018