BookTrails Camp Overnight Physical Health Form

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Upload the completed form to your child's Active Network acount by June 1st, 2019.
Do not e-mail us forms, please!

To Parent(s)/Guardian(s): Complete this section and give this form to your child's health-care provider for review

Dates will attend camp: from ____________to___________
Month/Day/Year Month/Day/Year

Camper Name: ____
First Middle Last

☐ Male ☐ Female Birth Date ________________ Age on arrival at camp ______________
Month/Day/Year

Camper home 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.

Camper Name ____________ First ____________ Middle ____________ Last ____________ (For Camp Use) Cabin or Group____________ (For Camp Use) Session Code(s): ____________

If camper requires any medication at camp, prescription or OTC, a separate medication form must be filled out and signed by the physician. You must provide your own medications. Medication forms can be found here:

http://www.mybooktrails.org/camp-paperwork/

If camper requires an epipen or benedryl for an allergy, a separate allergy form must be filled out and signed by the physician. Allergy forms can be found here:

http://www.mybooktrails.org/camp-paperwork/

If camper requires an inhaler, a separate asthma form must be filled out and signed by the physician. asthma forms can be found here:

http://www.mybooktrails.org/camp-paperwork/

BookTrails will not distribute any medications at camp without the required forms accompanying the medications.

This form must be completed by a licensed physician.

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

ACA accreditation standards specify physical exam within the last 12 months.

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)***

You must also provide a signed medication form (see above).

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? (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(s)/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 City State Zip Code

Telephone: (_______)___________________ Date:_____________________

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