CAMPER HEALTHCARE RECOMMENDATIONS by LICENSED MEDICAL PERSONNEL FORM 2

This form was developed and reviewed by Glisson Camp and Retreat Center, LLC and based upon the Health Form 2 created by the American Camp Association

This form must be received by the Glisson office by May 15th. This form can be mailed (690 Camp Glisson Road Dahlonega, GA 30533), Faxed (706.864.9352), or scanned and emailed (summer@glisson.org).

GLISSON camp & retreat center

To Parent(s)/Guardian(s): Complete this section and give this form (Health Form 2) to your camper's healthcare provider for review.

Dates camper will attend camp: _____ (Month/Date/Year) to _____ (Month/Date/Year)

Camper Name: _____ (First) _____ (Middle) _____ (Last)

☐ Male ☐ Female Birth Date: _____ (Month/Date/Year) Age upon arrival at camp: _____

Camper Home Address: _____ (Street Address)

_____ (City) _____ (State) _____ (Zipcode)

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

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

Medical Personnel: Please complete all remaining sections of this form (Form 2). Attach additional information if needed.

Physical exam done today: ☐ Yes ☐ No (If "No," what was the date of their last physical? _____ (Month/Date/Year))

ACA accreditation standards specify physical exam within the last 24 months.

Weight: _____ lbs Height: _____ ft _____ in Blood Pressure: _____/_____

Allergies: ☐ No Known Allergies

- ☐ Dietary Allergies (Please List: _____)
- ☐ Medication Allergies (Please List: _____)
- ☐ Environmental Allergies (Please List: _____)
- ☐ Other Allergies (Please List: _____)

Describe Previous Reactions: _____

Diet and Nutrition:

- ☐ Eats a Regular Diet
- ☐ Has a medically prescribed meal plan or dietary restrictions (Please Describe: _____)

The camper is undergoing treatment at this time for the following conditions: ☐ None _____

Medication: ☐ No Daily Medications ☐ Will take the following prescribed medication(s) while at camp (name, dose, frequency): _____

Other treatments/therapies to be continued at camp: ☐ 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? (Please describe - attach additional information if needed) _____

"I have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically, emotionally, and socially 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) _____ (Zipcode)

Telephone: (_____)_____-_____ Date: _____ (Month/Day/Year)

This form was developed and adapted based upon the *Camper Healthcare Recommendations by Licensed Personnel Form 2* created by the American Camp Association.

Rev. 10/23 WR