TEEN HEALTHCARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL FORM

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

PARENT/GUARDIAN:
Please submit this form to admin@kehillahhouston.org.

MEDICAL PROFESSIONAL:
Please return this form to the parent or guardian.

PARENT/GUARDIAN:
COMPLETE THIS SECTION AND GIVE THIS FORM TO YOUR CHILD'S HEALTH-CARE PROVIDER FOR REVIEW

Program Year: _____ (YEAR) to _____ (YEAR)

Teen Name: _____ (FIRST) _____ (MIDDLE) _____ (LAST)

☐ Male ☐ Female ☐ Other Date of Birth: ____/____/____

Home Address: _____

_____ (CITY) _____ (STATE) _____ (ZIP CODE)

Custodial Parent/Guardian Phone: (____) _____

PARENT/GUARDIAN STOP HERE. REST OF FORM TO BE COMPLETED BY MEDICAL PERSONNEL.

The following non-prescription medications are commonly stocked and are used on an as needed basis to manage illness and injury. ***Medical personnel:*** ***Cross out those items the teen should not be given.***

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Phenylephrine (Sudafed PE)
Pseudoephedrine (Sudafed)
Chlorpheneramine maleate
Guaifenesin
Dextromethorphan
Diphenhydramine (Benadryl)
Generic cough drops
Chloraseptic (Sore throat spray)
Lice shampoo or scabies cream (Nix or Elimite)
Calamine lotion
Bismuth subsalicylate (Pepto-Bismol)
Laxatives for constipation (Ex-Lax)
Hydrocortisone 1% cream
Topical antibiotic cream
Calamine lotion
Aloe

MEDICAL PERSONNEL:
PLEASE COMPLETE ALL REMAINING SECTIONS OF THIS FORM. ATTACHED ADDITIONAL INFORMATION AS NEEDED.

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

ACA accreditation standards specify physical exam within 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 teen 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 the program:_____ (describe below) ☐ None

Do you feel that the teen will require limitations or restrictions to activity while at the program? ☐ 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 teen's health history, and have discussed the camp program with the teen's parent(s)/guardian(s). It is my opinion that the teen is physically and emotionally fit to participate in an active program (except as noted above)."

Name of licensed provider (please print): _____ Signature: _____ Title: _____

Office Address _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Telephone: (_____)_____ Date:_____