

(For Camp Use) Session Code(s): _____

(For Camp Use) Cabin or Group _____

Last

Middle

First

Camper Name _____

**CAMPER HEALTH-CARE RECOMMENDATIONS
by LICENSED MEDICAL PERSONNEL FORM 2**

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

Return this form to camp prior to *May 1st*

Black River Farm and Ranch
5040 Sheridan Line
Crosswell, MI 48422

forms@blackriverfarmandranch.com
Upload a PDF in the registration portal



Parent(s) / Guardian(s): Complete this section only and give to your health care provider to complete the camper physical. Be sure to review any concerns you may have noted in the health history form with your provider.

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.

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

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

Black River Farm & Ranch specifies 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 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? (*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: _____