Calumet PO Box 236 West Ossipee, NH 03890
603 539-3223 Fax 603 539-3385

Health Care Recommendations -To be completed by Licensed Medical Provider

You may substitute your physician's generic form for this page as long as the information provided is comparable.

Camper Name____ *** I EXAMINED THIS INDIVIDUAL ON__________(Date)**

(ACA accreditation and State of NH requirements specify exams within 24 months of camp attendance.)

DOB ___________ Weight ____________ * Height ____________ *BP _____________

In my opinion, the above camper ❑ is ❑ is not able to participate in an active camp program.

The camper is current on all immunizations. ❑Yes ❑No Please include a current immunization record

The camper is under the care of a physician for the following conditions ____

____

____

Recommendations and Restrictions at Camp

Treatment to be continued at camp ____

____

____

Medications to be administered at camp (name, dosage, frequency)

Med: ____ Dosage: _________________________Frequency: __________________

Med: ____ Dosage: _________________________Frequency:___________________

Med: ____ Dosage: _________________________Frequency:___________________

Med: ____ Dosage: _________________________Frequency:___________________

Any medically-prescribed meal plan or dietary restrictions____

____

Known allergies ____

____

____

Description of any limitation or restriction on camp activities ____

____

Additional information for health care staff at the camp ____

____

____

Signature of Licensed Medical Provider – Updated signature required each year

*Signature____

*Print Name____

*Title ____ *Date _________________________________

*Address ____

*Phone (_________)____ *Fax (_________)__________________________________