

Winter (until May 20)
 10179 Crosstown Circle
 Eden Prairie, MN 55344
 Fax 952.922.7149
 Voice 952.922.2545
 800.242.1909



Summer (after May 20)
 PO Box 1308
 Lake Hubert, MN 56459
 Fax 218.963.2447
 Voice 218.963.2339
 800.242.1909

2010 Physician Form

RETURN TO CAMP BY MAY 1st for all sessions. If registration is after May 1st, return ASAP. PLEASE PRINT

2010 MEDICAL RECOMMENDATION

Parents:

Have your physician or nurse practitioner complete this form if, in your opinion, information from your medical provider gives our program a better understanding of your child's health need(s). We rely on you to make that determination. This form is recommended for participation at camp.

To Physicians and Nurse Practitioners:

This child has enrolled in a summer residential program at our camp. The program includes physical activity (i.e., swimming, soccer, volleyball) and takes place in the Minnesota North Woods. Our healthcare staff will use your information to help meet needs of the person described.

Name of Camper: _____

Date of Birth: _____/_____/_____

Session Dates: _____

PLEASE PRINT

MD/NP Name: _____

Office Phone: (_____) _____ - _____

City/State/Zip: _____

Date this form was completed: _____

This child is under the care of a physician for the following reason(s): _____

Describe the treatment(s) to be continued at the camp for this child: _____

List prescription medication(s) that this person should take while at camp (provide medical order for administration): _____

This person is allergic to: _____

Should exposure occur, how should the allergic reaction be treated? If this an anaphylactic response, will this child bring an epinephrine device? _____

Describe significant physical findings regarding this camper and/or describe any limitations which may impact the child's participation in our program: _____

These generic medications, stocked in the camp Health Center, are used to manage illness or injury concerns and dispensed as directed via medical protocols signed by the program's supervising physician. **Cross out** those which are contraindicated for this camper:

Acetaminophen	Diphenhydramine	Ivy Dry	Triple antibiotic cream
Guaifenesin DM	Throat Spray	Pseudoephedrine	Calamine Lotion
Ibuprofen	Lice shampoo/cream	Silver Sulfadiazine	Chlorpheniramine
Chamomile Tea	Cough Drops	Tinactin	Loratadine

We may have neglected to ask something you feel is needed to adequately address the health needs of this child. If that is the case, please add your comments on a separate sheet. Thank you for helping provide a successful camp experience for this child.

Your signature: _____ **Date:** _____

Questions? Call our camp office at 800-242-1909