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 (_____)_____

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ASTHMA INHALER AND EPI PEN PERMISSION FORM

Pursuant to NH Law the following must be completed and submitted 4-weeks prior to attendance in order for your child to possess and use an asthma inhaler or epinephrine auto-injector.

Camper Name_____ Date of Birth_____

Permission is granted to Camp Calumet to allow my child to possess and use an
☐ Asthma inhaler / ☐ Epinephrine Auto-Injector

Parent / Guardian Signature_____

Print name_____Date_____

LICENSED MEDICAL PERSONNEL must complete the following for use of the above
☐ Asthma inhaler / ☐ Epinephrine Auto-Injector

1) Name of medication_____
2) Date of Medication Order _____
3) Route and Dosage of Medication_____
4) Frequency and Time of Medication Administration or Assistance_____

_____

5) Diagnosis and Any Other Medical Conditions Requiring Medications _____

_____

6) Any Special Side Effects, Contraindications and Adverse Reactions to be observed? _____

_____

7) Any severe adverse reactions that may occur to another child for whom the epinephrine auto-injector is not prescribed, should such a child receive a dose of medication? _____
8) Name of each required medication_____

_____

I hereby verify that_____ has a valid prescription, and the knowledge and skills to safely possess and use the following at Camp Calumet:

☐ Asthma Inhaler ☐ Epinephrine Auto-Injector

Licensed Medical Personnel Signature_____
Date_____ Print name _____
Business Phone (_____)_____ Emergency Phone (____)_____

If any of these criteria are not met, Calumet will not be able to allow your child to carry or store an asthma inhaler or epi-pen in the cabin/tent. Please contact Calumet with any questions regarding this policy.