

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 (_____) _____

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 <input type="checkbox"/> Asthma inhaler / <input type="checkbox"/> 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.