

# Health Care Recommendations by Licensed Medical Personnel:

S1

Name of Camper: \_\_\_\_\_ Date of Birth:(M/D/Y) \_\_\_\_\_

Dear Medical provider,

You are being asked to recommend this camper for the participation in a 25 day, sleep-away camp program. Fernwood Cove is an all girls summer camp located in Harrison, Maine. Our program is very active program including swimming, waterskiing, tennis, gymnastics, ropes and rock climbing, soccer and dance. Our terrain is hilly and we are in the woods close to southern Maine. The bunks are not air-conditioned and the girls are routinely exposed to insects, pollens, trees, molds, heat and humidity. If you require further information before recommending a camper to participate in our program please feel free to contact us at: 207-583-2381.

## Immunization History:

Please provide dates for immunizations: (Month/Day/Year) or attach a sheet with this information and the campers name and date of birth.

Vaccine:	Dates	M/D/Y	M/D/Y	M/D/Y	M/D/Y	M/D/Y
DTP						
TD (tetanus/diphtheria)						
Tetanus or booster						
Polio						
MMR						
Or Measles						
Or Mumps						
Or Rubella						
Haemophilus Influenza B						
Hepatitis B						
Varicella (Chicken Pox)						
Meningococcal (MCV4)						
Other						

## Which of the following has the participant had?

- Measles     Chicken pox     German measles     Mumps  
 Hepatitis A     Hepatitis B     Hepatitis C

TB Mantoux Test: Date of last test \_\_\_\_\_ Result:  Positive  Negative

## In the last 12 months has the participant had?

- Whooping Cough     Mononucleosis

## Medical Recommendation:

Please list in detail prescribed medication for use while at camp (name, dosage, time):

---

---

---

---

---

Known allergies (please include type of reaction that occurs):

---

---

Restrictions:

Activity restrictions \_\_\_\_\_

Diet restrictions \_\_\_\_\_

\_\_\_\_\_ BP \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

**I examined this individual on \_\_\_\_\_ . (Exam date must be within 24 months of camp attendance)**

**Based on the information presented to me and upon my examination of the participant, I recommend them in my opinion to be able to participate in an active camp program.**

**Signature of Licensed Medical Personnel:** \_\_\_\_\_

Printed: \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ Phone #: \_\_\_\_\_

**This form must be signed by licensed medical personnel in order to attend Fernwood Cove.**