Winter (until May 11)
7460 Market Place Drive
Eden Prairie, MN 55344
Fax 952.922.7149
Voice 952.922.2545
800.242.1909

Summer (after May 11)
PO Box 1308
Lake Hubert, MN 56459
Fax 218.963.2447
Voice 218.963.2339
800.242.1909

(To Be Completed by Physician/Nurse Practitioner/Clinic)

2019 Medical Form

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

REQUIRED MEDICAL INFORMATION

Parents:
Have your physician or nurse practitioner complete this form as information from your medical provider gives our program a better understanding of your child's health need(s).

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, and other physically challenging activities) 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	Naproxen	Pseudoephedrine	Calamine Lotion
Ibuprofen	Lice shampoo/cream	Silver Sulfadiazine	Chlorpheneramine
Bismuth tabs	Cough Drops	Tolnaftate	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.

Physician/Nurse Practitioner/Clinic signature: ______________________________ **Date:** ____________