Participant Name: _____

This page must be completed by a licensed medical professional.

Medical Personnel: This person will attend a wilderness trip lasting up to one week involving moderate physical activity, frequent contact with water, and reduced access to advanced medical care. Please review the participant's health history and complete the remaining sections of this form. Attach additional information if necessary. With questions, please call Camp Amnicon at 715-364-2602.

Date of Most Recent Physical Exam: _____
Camp Amnicon requires a physical within the last year.

OTC Medication
The following OTC medications are stocked in Camp Amnicon's first aid kits and are given as needed to manage illness or injury. Cross out any items the participant should NOT be given.

Triple Antibiotic Ointment	Diphenhydramine (Benadryl)
Acetaminophen (Tylenol)	Bismuth Subsalicylate (Pepto Bismal)
Aspirin	Hydrocortisone 1% Cream
Ibuprofen (Advil)	Saline Eye-Wash
Phenylephrine (Sudafed PE)	Pseudophedrine (Sudafed)

Allergies □ No known allergies
□ This participant is allergic to:
- □ Food (List):
- □ Medicine (List):
- □ Environmental (List):

Describe previous reactions.

Diet/Nutrition □ Eats a regular diet □ Requires the following dietary accommodations: *(Describe below)*

Prescription Medication □ No prescribed medications □ Will take the following medication(s) at camp: (Name, Dose, Frequency—describe below)

The participant is currently undergoing treatment for the following conditions: Describe below
□ None

Does the participant require any limitations or restrictions to activity while at camp? □ Yes □ No
If yes, what do you recommend? Attach additional information if needed.

I have reviewed the participant's health history. It is my opinion that the participant is physically and emotionally fit to participant in this camp program (except as noted above).

Name of licensed provider (please print) _____
Signature: _____ Title: _____
Office Address _____
Phone _____
Date _____