Camp Sojourner
Girls' Leadership Camp

MEDICAL EXAMINATION FORM

To be completed and signed by a ***Licensed Medical Professional***

To attend Camp Sojourner, a medical examination is required within 12 months of the camping session, dated after 7/31/16. If an exam was already done in that time period, your physician may be willing to fill out the form below without an additional exam, or you may submit a signed and stamped printout from another exam. **This form or another exam printout must be completed and signed by an approved, licensed medical professional (licensed physician or physician's assistant) in order to attend Camp Sojourner**. Please be sure this entire form is complete. Thank you for your cooperation.

I have examined_____ on the date of_____
(name of camp participant) *(date of examination)*

Blood Pressure: _____ Height: _____ Weight: _____

In my opinion, the above applicant ☐ **is** or ☐ **is not** able to participate in this summer's active camp program.

The applicant is under the care of a physician for the following conditions:_____
_____
_____
_____

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

PLEASE GIVE ALL DATES OF IMMUNIZATION FOR:

DTP _____
TD (Tetanus/Diptheria) _____
Tetanus _____
Polio _____
MMR _____
or Measles _____
or Mumps _____
or Rubella _____
Haemophilus Influenza B _____
Hepatitis B _____
Varicella _____

Recommendations and Restrictions at Camp

Treatments to be continued at camp: _____
_____

Medications to be administered at camp (name, dosage, frequency): _____
_____

Any medically prescribed meal plan or dietary restrictions: _____
_____

Known Allergies: _____
_____

Description of any limitation or restriction on camp: _____

_____

Additional information for health care staff at camp: _____

_____

Signature of Licensed Medical Professional:_____

Printed Name: _____ Title: _____

Address: _____

Phone: _____ Date:_____

The section below is for Camp Personnel uses only, please disregard:

Screening Record at Check-In
Date Screened: _____ Time: _____am/pm
Medications received (Prescription and non-prescription): _____
_____

Updates/additions to health history? ☐ Yes ☐ No If yes, _____
_____

Current health needs identified? _____
_____

Observational notes: _____
_____

Screened by: _____