Camp Sojourner
Girls' Leadership Camp

CAMP STAFF PHYSICAL FORM 2024

STAFF NAME: _____ **DOB:** _____

*The following must be completed by a **licensed medical provider**. Vaccination history should be uploaded into the camp system or attached.*

HEALTH EXAMINATION/FINDINGS:

I have examined the applicant. Date of examination: _____ *Exam must be dated after 8/3/22 for adults, after 8/3/23 for minors.*

BP: _____ Weight: _____ Height: _____

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program, including swimming.

Does this staff member have any dietary restrictions, physical limitations, developmental/learning delays? ☐ yes ☐ no

If yes, please explain: _____

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

_____

Current treatment to be continued at camp includes:

_____

Is the applicant "up to date" on immunizations? ☐ Yes ☐ No (Vaccination record to be attached.)

ROUTINE MEDICATIONS TO BE ADMINISTERED AT CAMP: Medication list may be attached to this form in lieu of completing grid below, but must also be signed by licensed provider. **Check here if no routine medications.** ☐

Name of Medication	Purpose	Dosage	When to administer

OTHER AUTHORIZED MEDICATIONS (for staff members under 18):

As this child's healthcare provider, you authorize that **unless otherwise noted in "Remarks" section below,** the medications listed below can be dispensed at the discretion of medical personnel at camp per dosage, schedule, and route indicated on the label.

Name of Medication	*Purpose*	*Remarks*	*Name of medication*	*Purpose*	*Remarks*
Tylenol (or generic)	pain or fever		Antibiotic Ointment	superficial cut/abrasion	
Pepto-Bismol (or generic)	upset stomach, diarrhea		Lice shampoo/cream	lice	
Benadryl (or generic)	allergic reaction (hive, insect bites)		Ibuprofen (or generic)	pain or fever	
Claritin (or generic)	nasal decongestant		Calamine Lotion (or generic)	allergic reaction (contact dermatitis)	

I certify that the medical history of this staff member is correct, and that she/they has medical clearance to engage in all activities, except for those noted on this form. I authorize that (unless otherwise noted in "Remarks" above) medications listed under Other Authorized Medications section can be dispensed at the discretion of medical personnel at camp per dosage, schedule, and route indicated on the label.

Signature of Licensed Medical Personnel _____ **Date** _____

Printed _____ Title _____

Address _____ Phone _____