Camp Sojourner
Girls' Leadership Camp

CAMPER PHYSICAL FORM 2025

CAMPER NAME: _____ DOB: _____

*The following must be completed by a **licensed medical provider** and **returned by June 1**. Vaccination history should be attached, along with insurance information, if applicable.*

HEALTH EXAMINATION/FINDINGS:

I have examined the applicant. Date of examination: _____ (Exam must be dated after 8/4/24.)

BP: _____ Weight: _____ Height: _____

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

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

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

If yes, please explain: _____

Does this child have any allergies besides food? ☐ 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:

_____

ROUTINE MEDICATIONS TO BE ADMINISTERED AT CAMP: Please list all prescribed and over-the-counter medications, vitamins, and supplements, if applicable. Our camp nurse cannot administer any items that do not appear on this form. A medication list may be attached to this form in lieu of completing grid below, but the that list must also be signed by a licensed provider.

Check here if no routine medications, vitamins, or supplements. ☐

Name of Medication	Purpose	Dosage	When to administer

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

Name of Medication	*Purpose*	*Remarks*	*Name of medication*	*Purpose*	*Remarks*
Tylenol (or generic)	pain or fever		Ibuprofen (or generic)	pain or fever	
Pepto-Bismol (or generic)	upset stomach, diarrhea		Claritin (or generic)	nasal decongestant	
Benadryl (or generic)	allergic reaction (hive, insect bites)				

Signature of Licensed Medical Personnel _____ Date _____

Printed _____ Title _____

Address _____ Phone _____