Medical Form for Campers

(1 of 3)

SUBMISSION INSTRUCTIONS: UPLOAD A SIGNED COPY OF THIS FORM DIRECTLY TO YOUR ONLINE APPLICATION BY ***MONDAY*** **MAY 18, 2020.**

This form is to be completed and signed by a licensed physician. The medical examination must be completed within 12 months of participation in all Camp Promise/Jett Foundation programs. You must also complete page 3 of this form, which asks for a complete list of medical equipment and medications (including vitamins, herbal and over-the-counter medications) that you will be bringing to camp.

Camper's Name _____ Date of Birth _____

Date of Examination _____ Gender ❑ Male ❑ Female Age _____

Primary Diagnosis _____

Other Diagnoses _____

Height _____ Weight _____ Temp _____ Pulse _____ Blood Pressure _____

Please list status, essential findings, deviation from normal:

EENT _____ GU _____

Lungs _____ Heart _____

Abdomen _____ Resp _____

Mouth/Teeth _____ Ears/Hearing _____

Neck/Thyroid _____ Skin _____

Lymphatics _____ Spine _____

Extremeties _____ Emotional Status _____

	Yes	No	Reaction/Notes
Does the camper have any allergies to medicine?	❑	❑	_____
Does the camper have any allergies to food?	❑	❑	_____
Does the camper have any allergies to anything else?	❑	❑	_____
Does the camper take any medications?	❑	❑	Please list on page 3

Has the camper had a seizure? ❑ Yes ❑ No If yes, date of last seizure_____

Please describe seizures:

When do they occur? _____

How often do they occur? _____

How long do they last?_____

Who should be notified if a seizure occurs? ❑ Parent/Guardian ❑ Physician

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Camper Name_____

Recommendations and Restrictions for Camp Promise

Please describe any illness, injury, operations, or communicable diseases or conditions that relate to this individual's condition or care:_____

_____

_____

Are there any treatments that need to be followed at camp? _____

_____

_____

Please use this space to provide any additional information about the camper's behavior and physical, emotional, or mental heath of which the camp should be aware. _____

_____

_____

Recommendations and Restrictions for Camp Promise

After examining the person herein described and reviewing their health history, **is it your professional opinion that this individual is medically & emotionally able to attend camp & engage in camp activities? (Check One)**

❑ Yes ❑ No

Do you have any restrictions or recommendations for this camper while they are at camp (e.g., no participation in adaptive sports, no swimming, no boating, etc.)? (Check One)

❑ Yes ❑ No

If yes, please list _____

_____

If the camper is eighteen years of age or older, does the camper have the mental capacity to make appropriate decisions for him or herself? (Check One)

❑ Yes ❑ No

Over-The-Counter Medication Authorization

I hereby give permission for the camp medical staff to administer to the camper the following (or similar brand of) checked over-the-counter medications if deemed necessary. Dosages will be administered according to directions on the bottle unless a physician has directed otherwise. Check all that apply:

- ❑ Acetaminophen
- ❑ Benadryl
- ❑ Dulcolax/MiraLax
- ❑ Fleet Enema
- ❑ Hydrocortisone cream
- ❑ Ibuprofen
- ❑ Imodium AD
- ❑ Pepto Bismol/Pepcid AC/Tums
- ❑ Sudafed

A PHYSICIAN* MUST SIGN IN THE SPACE PROVIDED BELOW. *Physician may not be a member of the camper's family.

I have examined the person herein described and reviewed his/her health history. It is my opinion that s/he is physically able to engage in any required activities, except as may be noted above, and is free of communicable or contagious disease.

Signature of licensed practitioner: _____ Date _____

Printed Name _____ Phone Number _____

Address _____ City, State, Zip _____

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Camper Name_____

Camper Medication List
Camp regulations require that all camper medications must be documented on this form and administered by camp medical staff. This includes all prescription medications (such as antibiotics, birth control pills, asthma medications, insulin, etc.) and all non-prescription medications (such as allergy pills, cold tablets, vitamins, antacids, etc.) Medications MUST be turned in to the medical staff when the camper arrives at camp.

NOTE: Camp medical staff will only administer the medications listed on this form according to the Indication, Dose, and Times Given as described below. If a camper's medication regimen changes between submission of this form and the start of camp, it is their responsibility to update this form and notify the Camp Director.

Please bring enough of the camper's medications for the full week of camp, plus two (2) additional days. All medications must be brought to camp in their original container(s) with original pharmacy label(s). **Medications not in their labeled packages will NOT be administered to campers.**

Medication	Indication	Dose	Times Given

Continue on a separate page, as necessary, but physician MUST sign any & all additional pages.

Please list the following medical eqipment this camper will use at camp (feeding pump, leg braces, C-Pap, Bi-Pap, cough assist, oxygen, etc.)

Name	Time to be used	Description/Settings

While we encourage campers to continue all medications at camp, please list any medications currently being taken by the camper that you've chosen, in consultation with the camper's treating physiciation, not to provide at camp.

Medication	Indication	Dose	Times Given

A PHYSICIAN* MUST SIGN IN THE SPACE PROVIDED BELOW.

*Physician may not be a member of the camper's family.

I have reviewed the above listed medication, equipment lists, and over-the-counter medication authorization and direct that they be provided to the named camp applicant as described above.

Signature of licensed practitioner: _____ Date _____

Printed Name _____ Phone Number _____

Address _____ City, State, Zip _____