Medical Form (Volunteers)

SUBMISSION INSTRUCTIONS: UPLOAD A SIGNED COPY OF THIS FORM DIRECTLY TO YOUR ONLINE APPLICATION **BEFORE 3 WEEKS PRIOR TO THE START OF YOUR CAMP(S).**

This form is to be completed by a licensed physician within 12 months of participating in your first Camp Promise/Jett Foundation program. It is valid for 24 months, at which time it will need to be completed based on a new exam.

Volunteer's Name _____ Date of Birth _____

Date of Examination _____ Gender _____ Age _____

Height _____ Weight _____ Temp _____ Blood Pressure _____

Please list status, essential findings, deviation from normal:

ENT _____ GI/GU _____

Lungs _____ Heart _____

Resp _____ Abdomen _____

Ears/Hearing _____ Mouth/Teeth _____

Neck/Thyroid _____ Skin _____

Lymphatics _____ Spine _____

Extremities _____ Emotional Status _____

Does the volunteer have a seizure disorder? ❑ Yes ❑ No

If Yes, please explain _____

_____

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

_____

Volunteer Medications

Camp regulations require ALL medications be stored by the camp medical staff. All prescription medications (such as antibiotics, birth control pills, asthma medications, epipens, insulin, etc.) and all non-prescription medications (such as allergy pills, cold tablets, vitamins, antacids, etc.) MUST be turned in to the medical staff when the volunteer arrives at camp. Please bring enough medications for the full week of camp, plus two (2) additional days. All prescription medications must be brought to camp in their original container(s) with original pharmacy label(s). Continue listing medications on a separate page, as necessary.

Medication	Indication	Dose	Times Given

Medical Form (Volunteers)

SUBMISSION INSTRUCTIONS: UPLOAD A SIGNED COPY OF THIS FORM
DIRECTLY TO YOUR ONLINE APPLICATION **BEFORE 10 WEEKS PRIOR TO THE START OF YOUR CAMP(S).**

Volunteer Name_____

Over-The-Counter Medication Authorization
I hereby give permission for the camp medical staff to administer to the volunteer 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 ❑ Ibuprofen ❑ Benadryl ❑ Imodium AD ❑ Dulcolax/MiraLax ❑ Pepto Bismol/Pepcid AC/Tums
❑ Fleet Enema ❑ Sudafed ❑ Hydrocortisone cream

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?**
❑ Yes ❑ No

If no, please explain:
_____
_____

Do you have any restrictions or recommendations for this volunteer while they are at camp? ❑ Yes ❑ No

If Yes, please list (e.g., restrictions on lifting or providing personal care for campers, participating in sports, swimming, horseback riding, boating, etc.) _____
_____

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

A PHYSICIAN* MUST SIGN IN THE SPACE PROVIDED BELOW, ATTESTING THAT SHE/HE HAS:
***Physician may not be a member of the volunteer's family.**

1) Reviewed the medications listed on this form and the Over-The-Counter Medication Authorization statement above, and direct that these medications may be provided to the named camp applicant as described on this form.

2) Examined the person herein described and reviewed his/her health history. It is their 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 _____