

2010 STAFF MEDICAL EXAM/PHYSICIAN FORM

Prior to May 15th, please return to CAMP KAMAJI FOR GIRLS, 7436 Byron Place, St. Louis, MO 63105
After May 15th, please return to CAMP KAMAJI FOR GIRLS, 32054 Wolf Lake Road, Cass Lake, MN 56633

To Physicians: This person has enrolled to work in a summer residential program at Camp Kamaji for Girls. This program includes physical activity (i.e., swimming, canoeing, tennis, horseback riding, climbing wall!!) and takes place in the Minnesota North Woods. Our healthcare staff will use your information to help meet the health needs of the person described.

NAME: _____ **BIRTHDATE** _____ **AGE** _____

HEIGHT: _____ **FT.** _____ **IN.** _____ **WEIGHT:** _____ **LB.** _____ **BP:** _____ **RESTING HEART RATE:** _____

This person's immunization record is up-to-date. Yes No **PLEASE ATTACH A COPY OF RECORD**
 This person is under the care of a physician for the following reason(s): _____

Describe any treatment(s) to be continued at Camp Kamaji for this person: _____

This person takes medication. Yes No **PLEASE LIST ALL MEDICATIONS (PRESCRIPTION AND OTC) ON OVERSIDE ALONG WITH DOSAGE AND REASONS FOR TAKING.**
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This person will suspend specific medication while at camp. Yes No **PLEASE LIST MEDICATION ON OVERSIDE AND REASONS FOR SUSPENSION** ●●●●●●●●●●●●●●●●

This person is allergic to: _____
Should exposure occur, how should the allergic reaction be treated? If this is an anaphylactic response, will this person be bringing an epinephrine device?: _____

Describe significant physical findings regarding this person and/or describe limitations which may impact the person's participation in camp's program: _____

Mental, Emotional and Social Health: Please check any that apply and explain further on overside.

- This person has been diagnosed with Attention Deficit Disorder (ADD) Or ADHD.
- This person has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder.
- This person has an emotional health concern (specify _____)
 - During the past academic year, this person has seen or is currently seeing a professional to address mental/emotional concerns.
 - This person has had a significant life event that continues to affect her/his life at camp.

Over-The-Counter Medications (OTCs): These medications, stocked in Kamaji's Health Center, are used to manage illness or injury concerns and are used on a as needed basis to manage illness and injury. **PLEASE CROSS OUT** those which are **CONTRAINDICATED** for this person:

Acetaminophen	Cough Drops	Hydrocortisone Cream 1%	Musinex
Aloe	Benadryl 25 mg	Kaopectate	Naproxin
Antibiotic Ointment/Cream	Duoderm	Loperamide (Immodium)	Nix/Rid
Antifungal Spray/Cream (Tinactin)	Guaifenesin (Robitussin)	Maalox/Mylanta	Orajel (Benzocaine Dental Gel)
Bismuth Chew Tablets	Ibuprofen	Metamucil	Pseudoephedrine (Sudafed)
Bismuth Subsalicylate	Chloraseptic	Miconazole (Monistat)	Silver Sulfadiazine
Calamine (Caladryl) Lotion	Ivy Dry	Milk of Magnesia (MOM)	Simethicone (anti-gas)

— please turn over —

STAFF MEMBER'S NAME: _____

MEDICATIONS this person usually takes but which are being **SUSPENDED** during the time she is at camp and

REASONS FOR SUSPENSION: _____

Please list all **MEDICATIONS**, both prescription and over-the-counter, **TO BE ADMINISTERED** at Kamaji (name, dosage, frequency) and reason for taking.

Name of Medication	Reasons for Taking It	Doses Given and When
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Lunch Dose: _____ <input type="checkbox"/> Dinner Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Lunch Dose: _____ <input type="checkbox"/> Dinner Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Lunch Dose: _____ <input type="checkbox"/> Dinner Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Lunch Dose: _____ <input type="checkbox"/> Dinner Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____

We may have neglected to ask something you feel is needed to adequately address the health needs of this person. In that case, please add your comments below. Thank you for helping provide a successful camp experience for this person.

I have examined the person herein described. This person is physically able to engage in all camp activities, except as noted.

Signature of Examining Physician/Nurse Practitioner: _____

Date of Medical Examination: _____

Print or Stamp Physician's Name: _____

Address: _____

Phone and Pager (w/Area Code): _____