

2011 CAMPER/CIT/STAFF MEDICAL EXAM/PHYSICIAN FORM

Prior to May 15<sup>th</sup>, please return to CAMP KAMAJI FOR GIRLS, 7436 Byron Place, St. Louis, MO 63105

After May 15<sup>th</sup>, please return to CAMP KAMAJI FOR GIRLS, 32054 Wolf Lake Road, Cass Lake, MN 56633

To Physicians: This person has enrolled 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. ●●●●●●

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 as needed basis. PLEASE CROSS OUT those which are CONTRAINDICATED for this person:

Table with 4 columns of medication names: Acetaminophen (Tylenol), Calamine (Caladryl) Lotion, Immodium, Pseudophedrine (Sudafed), Acetic Acid, Chloraseptic Spray, Lice Shampoo, Silver Sulfadiazine, (for swimmers ear), Cough Drops/Syrups, (Ovide, Elimate, Nix), Simethicone (anti-gas), Aloe, Cold Formulas, Loperamide, Tums, Antibiotic Ointment/Cream, Duoderm, Maalox/Mylanta, Visine, Antifungal Cream/Spray, Guaifenesin, Metamucil, Other (please list), (Tinactine), (Robitussin, Musinex), Micanazole (Monistat), Antihistamines/Allergy, Hydrocortisone Cream 1%, Milk of Magnesia, Medicines (Benadryl, Ibuprofen, Naproxen, Clariton, Zyrtec), Ivy Dry, Orajel

**CAMPER/CIT 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 and have discussed the camp program with the camper's parent(s)/ guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted on overside.)

Signature of Examining Physician/Nurse Practitioner: \_\_\_\_\_

Date of Most Recent Medical Examination: \_\_\_\_\_

Print or Stamp Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone and Pager (w/Area Code): \_\_\_\_\_