



CAMPER PHYSICAL FORM 2026

CAMPER NAME: _____ **DOB:** _____

*The following must be completed by a **licensed medical provider** and **returned by 6/1**. Vaccination history should be attached, along with insurance information, if applicable. Please note, Camp Sojourner is required to provide vaccination records to NJ State as part of our permit.*

HEALTH EXAMINATION/FINDINGS:

I have examined the applicant. Date of examination: _____ (Exam must be dated after 8/3/25.)

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? 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 _____