

## **SPIRIT CAMP GENERAL MEDICAL EVALUATION**



(To be completed by family physician by June 19, 2022)

Camper's Name:				
Diagnosis:				
Date of Last Exam:				
Height:	Weight:	_ Weight:		
Does individual have a history of seizures:	Yes □ No			
Date of last seizure:	Туре:	Frequency:		
Presently controlled: ☐ Yes ☐ No				
Recent surgeries – (dates):				
Is individual restricted from: ☐ Swimming ☐				
Special concerns/limitations:				
Are immunizations up to date: ☐ Yes ☐ No Need a copy of your child's immunization	ns from your family	ohysician.		
Date of last tetanus: This should be administered if not up to date				
Does your child have any other medical or men	ital health concerns	:		
Physician (Printed)				
Physician's Signature		 Pate		

Fax to: (605) 328-1514

Mail to: Spirit Camp, Tristan Hargens, Route # 6374, 1305 W 18th Street, PO Box 5039 Sioux Falls, SD 57117-5039

Online Upload: sanfordhealth.org (keyword: Sanford Camps)

**Medication during camp:** Medications are dispensed at each meal and at bedtime. We would prefer to give as many evening medications as possible with supper. If the evening medications must be given at bedtime, please indicate this below.

Name of Route Medication (Mouth, IV, SQ,	Route (Mouth, IV, SQ, etc.)	Dosages	Frequency (include even/odd days)	Circle the time of day to be given	
				AM	NOON
				PM	BED
				AM	NOON
				PM	BED
				AM	NOON
				PM	BED
				AM	NOON
				PM	BED
				AM	NOON
				PM	BED
				AM	NOON
				PM	BED
				AM	NOON
				PM	BED
				AM	NOON
				PM	BED
				AM	NOON
				PM	BED
				AM	NOON
				PM	BED
				AM	NOON
				PM	BED
				AM	NOON
				PM	BED
				AM	NOON
				PM	BED